2010

2011

ANNUAL REPORT

Alberta Health Services

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Letter of Accountability

We have the honour to present the annual report for Alberta Health Services for the fiscal year ended March 31, 2011.

This annual report was prepared under the Board's direction, in accordance with the *Government Accountability Act*, *Regional Health Authorities Act* and directions provided by the Minister of Health and Wellness. All material economic and fiscal implications known as of June 30, 2011 have been considered in preparing the Annual Report.

Respectfully submitted on behalf of Alberta Health Services Board,

(Original signed by Ken Hughes)

Ken Hughes
Chair, Alberta Health Services Board

Welcome to the 2010 – 2011 Annual Report

Transformation is the word that may best describe the past year for Alberta Health Services. We have been focused on consolidating and organizing our services, delivering these services more efficiently and effectively, and building a solid foundation for health care in this province. We have been laying the groundwork for change.

Looking back, we can see how far we have come as an organization. This report is a representation of year two of operations for Alberta Health Services. Through the efforts of our staff, physicians and volunteers who continue to uphold the highest standards in health care, AHS is building on that foundation and rising to the challenges we face as a new organization.

We are very proud of the work that is being done, but we acknowledge that we must continue to build on the current momentum to make further improvements. This Annual Report also provides detailed information on progress on our performance measures and financial expenditures. It's a testament to our commitment to improve the quality, accessibility and sustainability of health care in this province. We turned the corner in 2010, and in the years ahead we see AHS yielding the benefits of amalgamation.

We are focused on what our patients need and how we can better serve them. We will build on the great work being done in every corner of Alberta.

These small steps are adding up to the greater strides that will move us forward.

(Original signed by Dr. Chris Eagle)

Dr. Chris Eagle
President and CEO

Our Stories

The stories in the following pages provide a sampling of the accomplishments we have celebrated this past year and the initiatives that are making a difference in the way health care is being delivered. We have highlighted stories from six areas within Alberta Health Services:

Staying Healthy and Health Promotion

Achieving and maintaining health is an ongoing process. We are developing programs and services and offering information for staying healthy and improving health throughout one's life.

Building a Primary Care Foundation

Our primary care providers are most often the first point of contact in health care. We want to assist them in their work by implementing supports and services that aid Albertans in preventing illness, managing diseases and improving wellness in their communities..

Reducing Wait Time and Improving Access

We have taken many steps in the delivery of our high-priority services to decrease the wait times and improve access for patients. We are beginning to experience the resulting change and these stories provide a view of how the health care landscape in our emergency departments, surgical services and cancer care is undergoing transformation.

Seniors

For seniors, there is often no place like home. There are many health benefits in remaining where we are most comfortable and supported. Across Alberta, there are programs that aim to provide seniors with more choices for care and enable them to stay in their homes and communities as long as possible.

Enabling Our People and One Health System

Perhaps the improvements that have the greatest impact are the ones we make to enable our people and system to operate in the most strategic and efficient ways. This section of the report demonstrates some of the incremental changes that result in big improvements to the way patient care is delivered.

Innovations and Research

You will find brief descriptions of innovative initiatives and research that are happening at every level of this organization.

Airdrie Teen Clinic Provides Complete Care

An innovative, collaborative approach to providing care is making a huge difference in the lives of teens and young adults in Airdrie.

The Airdrie Teen Clinic opened at the Airdrie Regional Health Centre in April 2010 and has already helped more than 500 young people.

Sexual and reproductive health services – contraceptives and sexually transmitted infection (STI) testing and treatment – commonly associated with a teen clinic are available in Airdrie, but the clinic offers much more than that.

Youth regularly visit to discuss addiction and mental health concerns, relationship issues, eating disorders or anything else that is troubling them, either physically or mentally.

Parents also come to the clinic to learn strategies to deal with their teens.

"The reason the clinic is so unique is it is not just about sexual and reproductive health like many other teen clinics," says Meg McDonagh, nurse practitioner at the Airdrie Teen Clinic. "We have a mental health therapist and an addictions counsellor on site, both of whom can often see patients right away."

Clinic staff can refer patients to mental health or other community agencies as needed. Referrals have even been made to the food bank. All visits to the clinic are confidential, which is a huge plus for many of the young people who go there.

Wendy Timmermans, a public health nurse at the clinic, says: "Not many kids will walk into their family doctor's office or urgent care and say, 'I'm anxious and I need help.' But that's exactly what kids are coming in here and telling us."

Nancy Adams, principal of Bert Church High School in Airdrie, is an advocate for the clinic and has been known to bring students to the downtown facility.

"It's a real blessing because young people will go there," Adams says. "A few students tried it out at the beginning and then others heard about the care provided and the confidentiality aspect. The clinic has helped a lot of students address their needs. ■

Staying Healthy and Health Promotion

Podcasts Help Newcomer Parents in Five Languages

Parenting is hardly a picnic at the best of times. For many newcomers to Canada, it's one more ball to juggle as they learn a new language and build a new life.

Now new immigrants can get parenting help in their own language through an Edmonton-produced audio series that's available free over the Internet.

Developing Children, Developing Parents is a 23-chapter podcast developed by the Alberta Network for Safe and Healthy Children, in partnership with Alberta Health Services.

The podcasts were made available in January 2011, in Somali, Mandarin, Sudanese Arabic, European French and Spanish at www.albertahealthservices.ca/safechildren.asp. They address topics related to healthy pregnancy, child development and parenting skills through a series of friendly conversations between a mother, father and nurse-narrator.

The podcasts have been available for download since January, yet their helpful tips and practical advice have already impressed Chinese emigre Sally Lo — mother to Kaylee, 5, and Kameron, 1 — on everything from how to best care for her children when they're ill and how to get them to settle down to sleep at night.

Sally Lo shares playtime with her children Kameron, 1, and Kaylee, 5, and Susan Patenaude of the Alberta Network for Safe and Healthy Children, in The Beach family rec area at Stollery Children's Hospital in Edmonton.

Audio podcasts are a good medium to reach to new Canadians, says Susan Patenaude, provincial co-ordinator for the Alberta Network for Safe and Healthy Children.

"Not all immigrants are literate in their own language," she says. "Many have never had the opportunity to learn written English or their own written language. Our audio resource is manageable. They can listen while they're taking care of the kids, or while they're doing other activities. This seemed like a more user-friendly way of reaching people with information."

Innovations and Research

Breaking Down Barriers to Care

AHS in partnership with Primary Care Networks are reaching diverse populations in Alberta to help them manage chronic diseases and improve their health. In Taber, three health professionals at the Associate Medical Centre fluent in Low German, have been specifically hired to help the area's growing Mennonite population navigate the health system and communicate with doctors, nurses and other health workers. This partnership helps address the primary care needs of diverse populations in both rural and urban settings.

Helen Thiessen, left, helps Low German- speaking residents such as Johan and Katharina Banman of Taber with their health care needs.

Life-Saving Exercise

A North Zone exercise program designed for those living with chronic conditions launched a stream-lined referral process in February 2011. In the eight-week Living Well program, an exercise therapist teaches participants practical exercises to use in their daily lives. The new system enables participants to gain strength, endurance, flexibility and balance in a safe, supervised environment. "My circulation has improved, pain decreased and I lost some inches around the waist," says Geoffrey Haiden, a Bonnyville resident, who lives with diabetes and underwent open heart surgery previously. Ultimately, the program aims to encourage participants to be independent with the exercise, beyond the program.

Better Beginnings for Babies

Better Beginnings — a Lethbridge-area program that teaches disadvantaged pregnant women to cook — helps increase participants' babies' birth weights and increases breastfeeding rates — was the only Alberta program invited to share their best practices at the national Birthing the World conference in Quebec, held in November 2010. Better Beginnings has seen tremendous results in providing support for disadvantaged pregnant and parenting women who may not have family or other supports. The women learn about safe food handling, meal planning and healthy snacks. The work with at-risk pregnant women is helping them make better health choices.

Delivering Options for Expectant Moms

Barb Bodiguel, Registered Midwife (R) supported new mom Tylene Yellowface (L) with her prenatal care and the birth of her baby.

Barb Bodiguel is a Registered Midwife in Rocky Mountain House delivering a unique service to both community residents as well as those living on the local First Nations reserves.

Working along side physicians and with the support of the Rocky Mountain House Primary Care Network (PCN), Bodiguel provides midwifery led births at the Rocky Mountain House Health Centre. She also supports local moms with prenatal and postnatal care at the Rocky Medical Clinic and the Sunchild First Nations and the O'Chiese First Nations Health Centres.

"I visit the reserves once a week," says Bodiguel. "I take along the Primary Care Network (PCN) computer which gives us direct access to the medical clinics electronic medical record (EMR). With this I can provide full scope midwifery care including lab services right there at the Health Center."

Bodiguel says uptake for her services has been phenomenal both on and off reserve but she is particularly proud of the innovation and collaboration between Alberta Health Services, the local PCN and Health Canada to reach First Nations women. Chief and Council for both communities as well as many elders, have also supported the program.

"This is a great way to offer care to the women in their own community," says Bodiguel.

The majority of women who see Bodiguel on reserve also have her deliver their babies. With the integrated model of care, local physicians can also step in to provide support when needed.

In 2010, Alberta Health Services and the Alberta Association of Midwives established a collaborative alternative model of midwifery care that incorporates both physicians and midwives working together to support low risk deliveries.

This alternative model supports expectant mothers by providing them with consistent care delivered by a team of health care providers. The model has improved access to obstetrical services within rural communities in Alberta.

Currently, the alternative model of midwifery care is available in Rocky Mountain House and High River. AHS is continuing to look for opportunities to expand this model into other rural communities. ■

Building the Primary Care Foundation

Building Access to Primary Care Networks

May 2010, marked the fifth anniversary of the launch of Alberta's first Primary Care Network (PCN).

PCNs are a made-in-Alberta approach to improving access and better coordinating primary health care for Albertans. The recent addition of the new Wainwright Primary Care Network brings the province to a total of 40 PCNs.

In a PCN, family physicians and other health professionals work together as a multi-disciplinary team to increase Albertans' access to primary health care when they need it, where they need it and from the appropriate provider.

As of March 31, 2011, 2216 family physicians work in PCNs and hundreds of other health care providers such as nurses, nurse practitioners, social workers, pharmacists and dieticians are providing innovative primary care to more than 2.5 million Albertans.

"I think the days of the person in the white coat coming in and telling you what should be done are in the past," says Dr. Nicholas Myers, AHS Primary Care medical lead.

"There's much more benefit to be derived in a partnership. This concept of getting all the information on the table makes sense, everyone can understand, and make an informed decision."

Alberta's 5 Year Health Action Plan identifies the strengthening of primary health care as a priority area in the province's health system. The Plan sets out a number of actions to strengthen primary health care and better connect Albertans to family doctors and other members of the health care team.

Alberta's AIM (Access, Improvement, Measures) Program is having a huge impact on improving wait times and increasing access at primary care clinics.

Alberta Health Services delivers the AIM Program bringing groups of family doctors and their teams together in learning collaboratives. They meet with a facilitator four to six times a year to learn about measures and strategies to improve access. Between sessions, they try new strategies, learn what works and share best practices with the larger group.

"Patient access is the main deliverable essential for quality health care," says Dr. Mike Donoff, director of the Royal Alexandra Family Medicine Centre in Edmonton and an early AIM alumnus. "This isn't about running an efficient practice just for the sake of it. It's about ensuring our patients get the best care".

After the AIM experience, Donoff's 10-doctor practice added 500 new patients in two years.

Funded through Alberta Health and Wellness and the Health Workforce Action Plan, AIM is operated in partnership between Alberta Health Services, the Alberta Medical Association, Toward Optimized Practice, Primary Care Initiative and Alberta physicians. ■

Innovation and Research

Hearing Restored in Edmonton ▶

More people who feared they were deaf for life in one or both ears can now hear thanks to the growing Bone Conduction Amplification Program at the Institute for Reconstructive Sciences in Medicine in Misericordia Hospital. During surgery, a titanium screw is implanted behind the ear. After healing, a bone-conduction hearing aid clips onto the screw, instantly restoring hearing. The research institute is a joint initiative of AHS, Covenant Health and the University of Alberta.

East Calgary Health Centre

This new community-based care centre opened on September 27, 2010, with more than 30 clinics and programs spread over 75,000-square feet under one roof. Services here include primary care, public health, chronic disease management, oral health, living well, addiction and mental health services, speech language services, and asthma and chronic obstructive pulmonary disease services.

Michael Brown holds up a prosthetic ear crafted for him at the Institute for Reconstructive Sciences in Medicine in Edmonton. Born without a right ear and deaf on that side, the 41-year-old Calgary father of two received a bone-amplification hearing device that vibrates sound through his skull to his healthy inner ear

Cardiac Rehab

Northern residents can now access cardiac rehabilitation, regardless of where they live, thanks to a new Alberta Health Services' resource. The Heart Manual comprises booklets and a CD of relaxation sounds to support patients with coronary artery disease and their families following discharge from hospital. It gives advice on how to exercise safely, reduce stress and make lifestyle changes to preserve heart health.

Support for Students with Severe Mental Health Needs

In January 2011, Alberta Health Services and the Fort McMurray Public School District teamed up to enhance mental health services for children ages three to 17 in the city's 12 public schools.

Removing Barriers is a collaborative project that aims to help students, with a diagnosed mental health disorder, who are experiencing severe symptoms that affect their ability to be successful in school. Many of these students have severe anxiety disorders, depressive disorders and/or post-traumatic stress disorders.

Alberta Health and Wellness provided the school district with a $500,000, three-year grant for mental-health resources, which include a psychologist with school-based expertise. Acting as a mental health co-ordinator, the psychologist links children and families to the local services of the AHS children's mental health team, works with existing school-based counselling services, and trains school staff in understanding mental health needs.

"It's important that mental health disorders are identified and treated early." says Donna Contant, director of Alberta Health Services Addiction and Mental Health for northeast Alberta. "By helping these students during their school years, we expect they will be better able to manage the disorders throughout their adult years."

About 5,200 students are in Fort McMurray's public school system; roughly 100 of whom could be identified as having severe mental health needs.

"Removing Barriers allows us to enhance existing resources and develop greater connections with our local mental health therapists to support the work of our school staff," says Dr. Brenda Sautner, director of student services for the school district.

As part of the province's Children's Mental Health Action Plan, Removing Barriers aims to increase the number of mental health service delivery practices and/or models in schools to address the needs of children and youth at risk, using collaborative partnerships and joint decision-making between health services and schools. ■

The Voice of Rural Alberta

What does the future of health care look like in your community? The needs of St. Albert are much different than the Crowsnest Pass and residents of Grande Prairie may require different health programs than those in Ponoka.

Understanding the unique health demands of rural Alberta and creating a consistent planning process for the future is the focus of Alberta Health Services' Community and Rural Health Planning Framework.

"The first phase of the Planning Framework began in the fall of 2010," says Heather Toporowski, vice president of Community and Rural, Primary Care & Chronic Disease Management. "Since then we've held 31 meetings in 19 communities and talked with over 500 people. This process has been a wonderful learning experience that's generated some very innovative ideas."

Leduc Regional Parent Link co-ordinator, Tonya Sabourin, welcomed the chance to attend a community meeting in her area.

"Having the opportunity to speak and network with others in the region in regards to how we feel improvements could be made was insightful," says Sabourin.

The Planning Framework follows a standard process that can be tailored to local needs.

The process involved evaluating all geographic planning areas across the province and identifying those areas in immediate need of health service planning.

Data was then collected for those communities and validated by talking with the people that live and work in the area. This consultation took place between November 2010 and February 2011.

Local health leaders and key stakeholders compiled this information, identified priorities and will create three-year health action plans expected to be complete by the end of June 2011.

With phase one nearing completion, AHS will embark on phase two of the Community and Rural Health Planning Framework by identifying the next round of priority communities. This on-going process strives to eventually engage all of rural Alberta.

The Community and Rural Health Planning Framework is helping ensure the right level of service is available across Alberta and will support high quality health care that is accessible and sustainable well into the future.

Innovation and Research

Nocturnal Dialysis ▶

Medicine Hat renal patients can feel better and enjoy more free time thanks to nocturnal home dialysis. Conventional dialysis requires patients to spend four hours, three times a week, usually on a renal dialysis unit. With nocturnal home dialysis, patients hook up to the equipment as they retire, five or six nights a week. This slower, gentler form of dialysis, done over six to nine hours as they sleep, is easier on the body than faster, daytime treatments. Nocturnal dialysis was used by the first patient in Medicine Hat in November 2010.

Rhonda MacNeil, right, a registered nurse on the renal dialysis unit of Medicine Hat Regional Hospital, trains patient Patty Hanegan on how to use a home dialysis machine.

Managing Chronic Disease Online

An expansion of the Stanford Chronic Disease Self-Management program available in many Alberta communities is now reaching people who live in remote areas, who are too debilitated to get to in-person sessions, or who prefer to learn and interact by using the internet. This pilot, which ran from February to November 2010 was aimed at helping those with chronic conditions. Participants take part through a workbook and a series of on-line discussion topics and exercises. Outcomes were so positive that Alberta Health Services is launching it as a full service.

Pregnancy and Stress

Alberta Children's Hospital researchers are looking at the impact of pregnant women's moods and stress levels on the long-term health of their babies. About 300 women and their newborns are part of this three-year, $510,000 study, funded by the Canadian Institutes of Health Research and the Alberta Centre for Child, Family and Community Research. Babies' responses to mild stress can predict future outcomes in a variety of areas, including heart and mental health.

Rockyview General Hospital and Royal Alexandra Hospital Emergency Departments

It's a tale of two Emergency Departments in two cities — Rockyview General Hospital in Calgary and Royal Alexandra Hospital in Edmonton — but the positive results in both clearly show access and shorter-wait-time strategies are paying off for Alberta Health Services.

Interdisciplinary teamwork, fresh approaches and the establishment of Medical Assessment Units (MAU) in each hospital improved patient flow through both emergency departments over the past year.

In Calgary, Rockyview General Hospital (RGH) opened a new Emergency Department in June 2010 with more space and privacy for patients, state-of-the-art equipment and better working conditions for staff.

"Our ED is now seeing about 6,000 patients a month … an increase of 10 per cent over the last year," says Nancy Guebert, RGH vice president. "Yet, despite the increase in patients, we have experienced an improved flow across the entire site with a decreasing length of stay and increasing discharges."

One reason for the improved flow is the new No Patient Left Behind project; it established a process for treating mid-acuity patients that are not immediately seen for resuscitation or fast-tracked for minor injuries.

"These patients are sent from triage into the intake waiting room where they are seen by a nurse or physician and taken to a touch-down stretcher for assessment," says Guebert. "They are being seen about 22 minutes sooner."

In Edmonton, Royal Alexandra Hospital (RAH) has focused on measures aimed at improving wait times, says Joanna Pawlyshyn, RAH vice president.

Teams of clinicians, front-line staff, program leaders and physicians have come together to try new approaches. "We could not have seen improvements or implemented new initiatives without the commitment of our staff and physicians." adds Pawlyshyn.

As well as adopting the Over Capacity Protocols, the Royal Alex established a 21-bed Medical Assessment Unit (MAU), a Transition Unit and implemented a Lean strategy, aimed at eliminating waste and reducing incidental work.

Its MAU — a short-stay medicine unit that helps trim wait times for patients in Emergency by rapidly admitting, assessing and implementing care plans — opened in November 2010.

Rockyvew General Hospital in Calgary

The interdisciplinary team of Rockyview's 12-bed MAU has greatly reduced the length of stay — from almost 72 hours to 24 hours — since the MAU opened in February 2010.

RGH also started enhanced daily rounds, known as SWAT rounds, in December. A multidisciplinary team — nursing, allied health, community, transition services and administration — discuss and identify care and discharge plans for each patient.

The Royal Alexandra's Transition Unit opened in October with a focus on patients who no longer need hospital care, but who are not yet ready for discharge. The RAH also adopted some more efficient Lean strategies.

Improvements seen in the RAH Emergency Department include a 23-per-cent decrease in the time a patient spends in the ED between triage and seeing a physician, as well as a 9-per-cent decrease in the average length of stay for patients seen and discharged from the ED.

As for time spent in hospital, there's been a 20-per-cent decrease in the average length of stay in Emergency for patients admitted to the RAH.

Pawlyshyn says the positive impact these initiatives have had on RAH patient flow deserve special recognition; they occurred while total ED visits rose by 10 per cent and total medical admissions grew by 20 per cent. ■

Radiation Therapy Corridor Reduces Travel for Patients

Two years ago a cancer diagnosis for a patient outside Calgary and Edmonton meant a tough decision — travel hours daily for radiation therapy, or settling for alternative treatment.

Mary Ann Waldner was spared that painful choice thanks to a provincial Alberta Health Services strategy that is opening a corridor of cancer care treatment centres, bringing care closer to home.

The Jack Ady Cancer Centre in Lethbridge opened in June 2010 with radiation therapy as part of its services. As of March 31, 243 full courses of radiation therapy have been delivered.

Waldner, of Lethbridge, says being able to undergo treatment while surrounded by her family took a lot of the stress out of her fight against breast cancer.

"If I'd had to go to Calgary for radiation therapy, I would have been devastated. Going through cancer treatment is stressful enough without being forced to leave your family, who are your major support system."

Waldner had radiation therapy sessions while her children were at school.

"I was able to maintain a normal life. The kids didn't miss me, because when they came home from school I was there to meet them. If I'd been in Calgary, it would have been awful and a lot more stressful.

Waldner was also spared another painful decision. "There was a more extreme breast cancer surgery that did not need follow-up radiation, and I may have chosen that to avoid travelling to Calgary for radiation therapy. I'm glad I was not put in the position to have to make that decision."

Once the radiation therapy corridor is complete, Albertans who have to travel 100 km or more for radiation will be reduced to eight per cent from 28 per cent.

Ground was broken for the Central Alberta Cancer Centre in Red Deer in September 2010, with a 2013 opening date. The Grande Prairie Cancer Centre will be built as part of the new Grande Prairie Hospital, expected to be built by 2015.

The new centres will deliver a total of almost 32,000 individual radiation therapy sessions in their first year, which will help meet the growing service needs in southern, northern and central Alberta to 2025.

As well as providing patients with local care, the new centres will relieve pressure in Edmonton and Calgary, improving access to radiation therapy for all Albertans.

Innovation and Research

Robot Fights Cancer in Edmonton ▶

A high-tech surgical tool to treat gynecologic cancers – the robotic-assisted da Vinci System – is helping more women than ever before at the Lois Hole Hospital for Women, within the Royal Alexandria Hospital. "The precision of robotic-assisted surgery translates into less-invasive procedures and quicker recovery time," says gynecologic oncologist Dr. Tiffany Wells. On the Canadian prairies, only Edmonton offers this effective treatment option.

New gynecologic oncologist Dr. Tiffany Wells, recruited in summer 2010 to the Lois Hole Hospital for Women, located within the Royal Alex, uses the da Vinci robotic surgical system to help women in the fight against cervical cancer.

Cochrane Urgent Care

Urgent care, including laboratory and diagnostic imaging services became available locally on February 15 at the new Cochrane Community Health Centre. Previously, residents needed to go to Calgary or Canmore. Cochrane is a rapidly growing community and the introduction of these vital services will make health care much more accessible for our 15,000 local residents.

"Neon" Brain Glows

When a special dye is injected into his patient's blood, University of Alberta Hospital neurosurgeon Dr. Max Findlay switches over to infrared light on a new $380,000 Zeiss OPMI Pentero microscope. Within seconds, brain blood vessels light up like neon. This allows Findlay to see at a glance that his aneurysm surgery has been successful. This state-of-the-art illumination technique is known as fluorescence angiography.

Cancer Navigation Services

Cancer navigator Erin Langner, left, helped Fort McMurray patient Glenda Pollard through the cancer treatment process by explaining treatment choices and results, co-ordinating care and assisting with rehabilitation.

Patient navigators are working to guide cancer patients through treatment to improve their health-care experience.

"She gave me a lot of information, prepared me for my visit with the oncologist and connected me with resources I did not know about," says Fort McMurray cancer patient Glenda Pollard of her navigator, community cancer nurse Erin Langner.

When she met with her oncologist, Pollard says she knew what treatments she'd be having. "All of the questions I would have been wondering about were no surprise when I went there."

A cancer patient's journey can be more manageable with someone to turn to for advice. The navigators help alleviate the confusion that can accompany a cancer diagnosis, so the patient can put their effort into battling the disease.

The navigators explain treatment choices and test results, co-ordinate patient care and assist with psychological, physical and emotional rehabilitation following a cancer diagnosis.

Langner, who works at Northern Lights Regional Centre says she starts with "listening to a patient's needs and helping find answers to their questions". She also helps coordinate tests, treatment and care by working with other health care professionals on her patients' behalf.

Cancer navigation services are available in Fort McMurray, Drumheller, Lloydminster, Grande Prairie, Calgary and Edmonton. Specialist breast cancer navigators work in Edmonton, Calgary, Red Deer and Lethbridge. All navigators are intimately involved in the patient's care path from suspicion of cancer through to specialist treatment.

The First Contact Project, a separate effort, is underway in Calgary and Edmonton. This project ensures that patients and their physicians are contacted within 48 hours to confirm the referral has been received and to provide a contact number for a nurse to patients.

The goal is to reduce the time from when a physician refers a patient, to when they are seen by an oncologist. All cancer patients will be included in this project in Edmonton, Calgary, Grande Prairie, Red Deer, Lethbridge and Medicine Hat. ■

Reducing Wait Time and Improving Access

Orthopedic Surgery Centre in Edmonton Improves Access

Within two weeks of opening its doors, the new Orthopedic Surgery Centre (OSC) on the Royal Alexandra Hospital campus trimmed the stay for hip- and knee-replacement patients by a full day.

Last November, the Royal Alex transferred and consolidated low-intensity hip and knee surgeries into one, high-efficiency surgical environment. The new centre includes in-house central services, rehabilitation and basic diagnostic imaging capability.

"The centre was specifically designed to meet the needs of patients needing hip and knee surgeries," says Joanna Pawlyshyn, vice president, Royal Alexandra Hospital.

"By consolidating our low-intensity surgeries in one location, we are able make more efficient effective use of our health professionals' time and energy through the use of consistent care pathways and best-practice processes to ensure the healthiest outcomes for the patients served here."

Most in-patient rooms are private, to improve infection control and add to patient satisfaction. Larger rooms allow patients and physiotherapists to move around easily and safely with aids, walkers and equipment. This contributes to quicker recoveries and shorter stays, which increases capacity for more surgeries.

"The Orthopedic Surgery Centre was designed to improve accessibility and quality of services, while sharing resources with the Royal Alex campus," says Dr. Don Dick, medical lead of bone and joint health in Edmonton.

By working collaboratively with the Alberta Bone and Joint Health Institute, the Orthopedic Surgery Centre will become a part of Alberta's first integrated provincewide network of bone and joint care, adds Dick. This model of research and treatment will see best practices developed faster, and bring laboratory discoveries to the bedside sooner. Ultimately, this will benefit all Albertans, not just those who reside in Edmonton.

The centre has new operating rooms, where 1,400 existing low-intensity arthroplasty procedures are being completed. New computerized laser navigation equipment, funded by the Royal Alexandra Hospital Foundation, allows for precise implant placement and improves surgery and patient outcomes.

When the Orthopedic Surgery Centre is operating at full capacity, it will support 3,500 to 4,000 cases a year. High-intensity surgeries will continue to be performed in the hospital's main surgical suite.

Innovation and Research

McCaig Tower ▶

The world-class McCaig Tower opened in October 2010, adding surgical capacity to Foothills Medical Centre in Calgary. The McCaig Tower is occupied by three in-patient units, intensive care unit (ICU), central sterile reprocessing department and three new operating rooms. The surgical activity in McCaig Tower focuses on orthopedic services for hip, knee and spine surgeries.

McCaig Tower at the Foothills Medical Centre in Calgary

Camrose Simulation

In the first simulation training session at Covenant Health St. Mary's Hospital in Camrose, operating room staff practised skills in many medical scenarios during a five-hour training session with a computer-controlled mannequin that breathes, blinks, talks, and has a pulse and vital signs. In 2010, AHS established eSIM (educate, Simulate, Innovate, Motivate), the only provincewide simulation program in Canada.

Knee Cartilage Grown in Lab

Alberta researchers are studying stem cells to improve the quality of life for those who suffer from osteoarthritis. The team is investigating the use of stem cells obtained from the knee fluid of people with osteoarthritis to grow artificial cartilage in a lab at the Foothills Medical Centre in Calgary. This innovative research study began in January 2010. The team is watching how knee stem cells grow and respond to treatment comparing them to healthy cells and looking for a genetic link to the disease.

No Place Like Home

A pilot project launched in 2010 is expanding and capturing national attention.

Emergency to Home: A Senior's Journey to the Right Care was introduced at Edmonton's Misericordia Community Hospital and Sturgeon Community Hospital in Edmonton, Red Deer Regional Hospital, and at Foothills and Rockyview General Hospitals in Calgary last year. The pilot project has been expanded to March 2012 and will be introduced in additional Emergency Departments in 2011.

Since it began, the project has assessed more than 15,000 seniors in the respective Emergency Departments. About 2,500 referrals have been made to home care which accounts for about 16 per cent of the seniors assessed in the Emergency Department. The target was to increase referrals to home care by 15 per cent.

The pilot projects provide funding for a care coordinator to work in the Emergency Department where he or she liaises with elderly patients. This nurse works with Emergency and Home Care staff to safely discharge patients and support them at home.

"Our overall goal with this pilot project is to better support Emergency Departments in seniors care," says Queenie Choo, executive director, Continuing Care Integrated Services Seniors Health. "We want to help prevent multiple repeat visits, prevent unnecessary admissions to hospital where possible, and better support seniors in the community by linking them with existing resources, programs, and services."

The project has captured the attention of the Canadian Association of Emergency Physicians (CAEP) and Choo and her team has been invited to the CAEP annual conference in June.

"With this initiative, we are working with Emergency Department nurses and physicians to determine whether an individual needs to be admitted to hospital or if, with the right supports, equipment, supplies and connections with home care, they can safely return to their own homes."

Often, the seniors encountered in the pilot project are living with one or more chronic conditions and need only a little help at home in order to cope and maintain quality of life.

"We have anecdotal evidence this program is preventing admissions and having some impact on repeat visits to emergency," says Choo. "While there may not be any direct causal relationship between this model and reduction in acute admission, we have observed in some pilot sites such as Red Deer Regional Hospital, that there is a 50 per cent reduction in acute admission based on the target population.

Provincially, seniors account for up to 20 per cent of all emergency department visits. They come in for various reasons – falls, digestive problems, circulatory issues, heart problems and diabetes are among the top complaints.

"Sometimes a simple adjustment to a senior's routines, care or medications will allow them to stay where they are most comfortable," Choo says. ■

More Options for Independence

It seems the catch-all term for addressing challenges within Choice and Quality for Seniors is capacity.

A great deal has already been achieved. In June, Alberta Health Services agreed to add 2,300 spaces within continuing care by March 2012. By March 31, 2011, Alberta Health Services opened 1,166 spaces. Alberta Health Services will add another 1,000 beds every year until 2015.

The vast majority are supportive living beds.

"Addressing capacity has also involved a massive amount of work," said David O'Brien, seniors health vice president. "We've completed new assessments on everyone who is waiting for a continuing care space to ensure they are appropriately placed in the right living option. In some rare instances, this work has identified seniors waiting for a long-term care bed who actually could be safely supported in their own homes."

The goal is always to try to find the right care in the right place and to make every effort to support seniors and adults with disabilities to remain in their own homes when it's safe to do so, says O'Brien.

"Seniors consistently tell us they want to stay in their own homes, they want to maintain their independence and control over their life and health," he says. "Above all, we want to balance respect for their wishes with keeping them safe."

Alberta Health Services continues to assure Albertans that long-term care will always be available for those individuals with complex, unpredictable medical needs who require 24-hour registered nurse supervision and care.

"We envision the future of long-term care as the Intensive Care Unit of the continuing care system," says O'Brien. "The days of individuals living 20 or 30 years in a nursing home are behind us – we can do so much more today to keep people health and at home."

Capacity doesn't just mean adding beds.

"We are also improving home care, health promotion, chronic disease management and rehabilitation services," he says. ■

Innovation and Research

Brain-in-Motion Study ▶

"Our hypothesis is that when you exercise, the blood flow to your brain increases, improving your thinking and memory skills, and protecting you from dementia, stroke and Alzheimer's disease," says study lead Dr. Marc Poulin, a member of the Hotchkiss Brain Institute. The study is recruiting 250 Calgarians – 125 women and 125 men – between the ages of 55 and 75 to watch over an 18-month period.

Georgie Leach, left, Andrea Lazaruk and Pat Graham walk on the track at the University of Calgary Olympic Oval. The three friends, all 75 this year, are participating in the Brain In Motion study which looks at how exercise can increase blood flow in the brain and possibly prevent dementia, Alzheimer's and stroke.

Better Parkinson's Speech

Persons with Parkinson's disease are receiving extra help to improve the power and clarity of their speech thanks to a new Alberta Health Services' program. Techniques on breath control, postural adjustment and voice modulation are taught during one-hour meetings of the Vocal Strengthening Group, established by speech language pathologists in Grande Prairie in fall 2010.

MRI Increases Access

A brand-new General Electric MRI for Chinook Regional Hospital "will allow us to do things we have not been previously able to do, such as higher resolution images and multiple contrast images, so we can see finer detail than before," says Peter Froese, AHS executive director of rural Diagnostic Imaging. "Faster exam set-up times mean we'll be able to serve more patients…. This is a major step forward."

Enabling Our People and One Health System

Red Deer is the Best in its Class

The Red Deer Regional Hospital Centre's laboratory has been deemed a LEAN best in class by Siemens' Healthcare Solutions. Richelle Miller, supervisor with lab services and chair of the LEAN committee, helped bring in LEAN initiatives, which earned the lab the distinction.

The laboratory at the Red Deer Regional Hospital Centre is always a flurry of activity, with more than 2.7 million tests performed annually. The 180 staff members carry out each test using some of the best practices available, which has earned the laboratory "international distinction" according to Siemens Healthcare Solutions.

"Typically when we collect data, we find six or seven, sometimes a dozen, best practices in place in a lab," says Sue McDonald, the Canadian-based manager in Healthcare Solutions with Siemens Healthcare Diagnostics, who inspected the laboratory last year.

"When we looked at what the lab in Red Deer is doing, we found 55 best demonstrated practices. It's a best-in-class lab."

Siemens Healthcare Solutions is a global group with a best practices database — based on the Lean efficiency method aimed at eliminating waste and reducing incidental work — built from its work with hundreds of labs around the world.

"It's certainly useful to know how we stack up globally," says Dr. James Wesenberg, clinical department head in Pathology and Laboratory Medicine for the Central Zone and medical/scientific director of Laboratory Services for regional and rural centres throughout Alberta. "We have integrated a number of best practices over the last few years.

McDonald explains that Siemens has 60 people in an independent group that collect data in laboratories, looking for best practices and assessing work flow where the Siemens brand exists. All laboratories are assessed on the same criteria.

Laboratory staff have worked hard to improve efficiency and best practices. "We've made a number of changes, including making things very visual and colour coded in the lab, with common best work practices and monitoring of data across each shift," says Denise Fern, the laboratory manager for the Red Deer site. "It's nice to hear that our work is being recognized, and that we're doing well."

Wesenberg hopes that other laboratories in Alberta will draw on the successes in Red Deer. "Already we've had a few visitors looking to model their labs on some of the things we've done."

As McDonald says, "There is such a positive atmosphere here, you can really feel that staff believe in what they're doing. Assessing this lab as a 'best in class' is because of the people and what they do every day." ■

Improving Care in the Royal Alex Emergency Department

Have you heard about Lean Six Sigma (LSS)? It's a process-improvement framework that eliminates activities that don't benefit the patient — and the Royal Alexandra Hospital is working to implement LSS in the Emergency Department (ED).

"This is really about improving processes in the ED," says Dr. Ruben Hansen, site chief, emergency department, Royal Alexandra Hospital. "Ultimately, it's going to reduce wait times for patients."

LSS reduces inefficiencies such as duplication of efforts, retesting, delays in receiving information or bed assignments, excessive patient transport and searching for orders, charts or supplies.

"The LSS initiative is funded in partnership with the Industry Development Branch of Finance and Enterprise at the Government of Alberta," says Carolyn Hoffman, executive director of the ED. "Through these initiatives, staff are enabled to work smarter — not harder."

"Staff are just as frustrated by long wait times as patients," says Kevin Harris, an ED registered nurse. "We're not changing or reducing important steps in the care path, just the inefficient ones."

During the first stage of LSS at the Royal Alexandra Hospital, staff and physicians laid the foundation for the project, determined its structure and put communication channels in place.

Currently underway, stage two will identify problem areas through a variety of ways. For example, during one exercise, staff mapped out every step a patient takes during triage to discharge.

Patient, staff and physician surveys have been utilized to ensure everyone has input into what could be changed so departments run more efficiently and wait times improve.

Harris also mentions that stage two will conclude with the selection and sequencing of three separate projects focusing on priority improvement areas. When the three projects are complete in August 2011, more efficient processes and better wait times are expected, and staff will have a working framework to better understand how to continue improving care process in other areas.

"This project has generated a lot of excitement," says Shinnel Diachinsky, a clinical nurse educator with almost eight years of experience in the ED. "We'll see some process changes that will improve workflow, staff morale, and most importantly, patient satisfaction." ■

Innovation and Research

Calgary Research means a Transplant First ▶

Twenty years of Alberta-based research into tissue preservation at Calgary's McCaig Institute for Bone and Joint Health culminated in 2010 in the first documented transplant of living cartilage into a shoulder. Dr. Mark Heard transplanted the live cartilage into the shoulder of Jim Chebib during a groundbreaking, two-hour procedure at the Banff Springs Mineral Hospital in March. The surgery restores joint structure and function.

Dr. Mark Heard transplanted living shoulder cartilage into the shoulder of Calgarian Jim Chebib in March 2010. Chebib, an avid soccer player, has since regained full movement in his shoulder.

Team Work in Worsley

Weekly visits by Fairview health professionals and the addition of a local nurse practitioner at Worsley Health Centre are improving access to primary care here. A family physician and RN from the Peace River/Fairview Primary Care Network now travel to the Alberta hamlet every Wednesday. They see up to 25 residents a week, treating coughs and colds, performing wound care and surgery follow-up, and can also bring medication refills to save patients the trip into Fairview.

EMS Brightens Rainbow

Fresh teamwork has improved health care in Rainbow Lake, a town of about 1,100 people, located 140 km west of High Level. Rainbow Lake Health Centre continues to deliver high-quality primary care, despite the departure in 2010 of a nurse practitioner, thanks to EMS personnel who have been brought into the clinic to provide primary care services including patient assessments, lab draws and suturing.

Coordination of EMS Resources Now Done from One Site

Dispatch is the backbone of EMS and the over-arching goal to consolidate dispatch remains sound: to develop a coordinated provincial approach that will improve the effectiveness, efficiency and responsiveness of EMS.

In March 2011, the Central Communications Centre in Edmonton completed the consolidation of emergency services, Medivac and inter-facility transfer dispatching onto one site.

New dispatch and administrative work areas were built and new communications and dispatch technology installed to ensure provincial dispatch coordination for ground, air and inter-facility transfer services from a central point.

Formerly known as the Provincial Flight Coordination Centre, the Central Communications Centre retrofit was done in two phases.

"Phase 1 which was completed on December 7, 2010 involved moving operations into the new communications room and transitioning the new Computer Aided Dispatch (CAD) system so that coordination and dispatch of inter-facility transfers and Medivacs could be done," says Stu Williams, Central Communications Centre director.

"We also moved to a new phone system specifically designed for handling emergency communications. The improved technology systems will facilitate more efficient use of resources and allows us to coordinate and dispatch all emergency medical services offered within the EMS portfolio."

Phase 2 was a renovation of the administrative area and it was completed in February.

On March 22, 2011 the Central Communications Centre assumed the responsibility for EMS 911 call taking and dispatching for the City of Edmonton. It now manages 400-450 emergency, inter-facility and Medivac events a day.

The Central Communications Centre is one of three AHS EMS dispatch centres that coordinate and dispatch ground, air and inter-facility resources. The consolidation of dispatch centres around the province has seen improved utilization of ambulance resources, by sending the closest and most appropriate resource.

The Northern Communications Centre is located at the airport between the towns of Peace River and Grimshaw, and the Southern Communications Centre is contracted to City of Calgary Public Safety. There remains 15 dispatch centres around the province that have yet to be consolidated. ■

Virtual Road Trip ▶

Getting back behind the wheel after injury or illness is now easier and safer for more Albertans thanks to a new driving simulator at the Glenrose Rehabilitation Hospital in Edmonton. One of the most advanced car simulators in North America, the Canadian-made Virage VS500M was designed and built in Montreal by former aerospace industry experts, and it's the only ride of its kind in a rehabilitation setting in Alberta.

Family-Centred Care

For parents, having to place their newborn with the Neonatal Intensive Care Unit (NICU) can be overwhelming. Shared Care Nursing at Red Deer Regional Hospital Centre now allows an NICU nurse to care for babies with medical needs (who do not need to be in the NICU) at the mother's bedside on the obstetrics unit. Simultaneously, the mother receives care from a postpartum nurse. Newborns kept with their mothers do better.

Innovative Training

A pilot project is helping AHS meet its promise to provide more than 3,000 more continuing care spaces in the next three years. AHS and partner CAREERS: The Next Generation are supporting high school students in obtaining health care aide (HCA) certification before Grade 12 graduation. The South and Central Zones have already seen 32 students complete their first internship and 14 complete their second internship.

Gift Lake Guardians

In the absence of a hospital, ambulance or local doctor or nurse, the 1,200 people of the Gift Lake Metis Settlement in northeast Alberta turn to Connie and Jennifer Anderson for health advice. In the 15-plus years the pair have worked as AHS community health reps, they have organized special clinics, program and information sessions for everything from postnatal advice for new moms to telling families about the benefits of immunization. Both were born and raised at the Métis settlement.

Apple Magazine

In October 2010, Alberta Health Services launched *Apple*, a free consumer health and wellness magazine. 120,000 print copies are circulated to some 1,700 internal and external sites, with a supporting website (applemag.ca) and Facebook page. The magazine contains easy to digest information on leading healthy lifestyles and reducing the risk of many health concerns, such as cancer, diabetes and obesity. In many instances, it can be a matter of simple, healthy choices. *Apple* helps readers learn more about those choices.

Jannelle Meredith, who had to relearn her driving skills after a stroke, takes the wheel of the new Virage VS500M driving simulator at the Glenrose Rehabilitation Hospital in Edmonton.

New Speech Tool

A new tool developed by front-line staff is showing early promise. Created by four Alberta Health Services speech-language pathologists, the Speech and Language Pathology Early Screening Instrument (SLPESI) identifies possible speech and language delays in children 18 to 21 months of age. Results of the pilot study were published in the Canadian Journal of Speech-Language Pathology and Audiology.

Building Better Care

A redevelopment at Medicine Hat Regional Hospital (MHRH) and an expansion to Chinook Regional Hospital (CRH) will improve delivery of care and reduce wait times. MHRH will expand ambulatory care and maternity services as well as the emergency department and operating rooms. CRH will expand its emergency department and inpatient areas, women's health and neonatal units.

Tabling the Motion

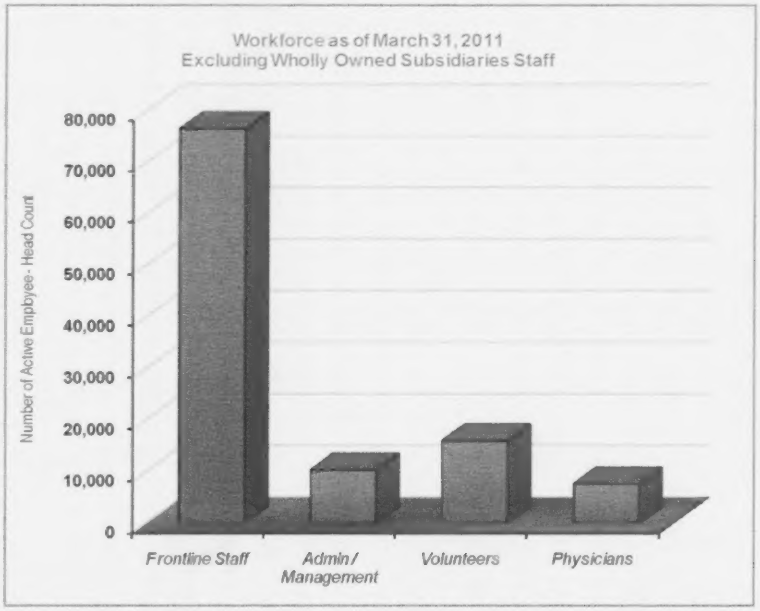
Glenrose Rehabilitation Hospital researchers, technologists and occupational therapists pooled their talents with University of Alberta computing science staff and students to create a touch-sensitive tabletop. The interactive tool marries a computer, digital projector, infrared sensing camera and dedicated software to help stroke, injury and surgical patients who require upper limb motor therapy to regain strength, co-ordination and reactive skills. Plus, it's fun!

Close-to-Home Cancer Care

Construction is underway on the Central Alberta Cancer Centre, a new facility that will offer radiation therapy for the first time in the area. The new CACC will be about three times the size of the existing centre, with added treatment and examination rooms, outpatient clinics, a medical day unit, radiation therapy and a pharmacy. "This will be a state-of-the-art facility where central Albertans will be able to access top quality care," says Ken Hughes, AHS board chair.

Who We Are

We are the skilled and dedicated health professionals, support staff, volunteers and physicians who promote wellness and provide care everyday to 3.7 million Albertans, as well as to many residents of southwestern Saskatchewan, southeastern British Columbia and the Northwest Territories. This includes approximately 92,000 direct AHS employees and approximately 7,600 staff working in AHS wholly owned subsidiaries such as Carewest, Capital Care Group and Calgary Laboratory Services (excludes Covenant Health staff), 16,000 volunteers and 7,675 physicians (total physician count for Alberta both employed and independent physicians). Students from Alberta's universities and colleges, as well as from universities and colleges outside of Alberta, receive clinical education in AHS facilities.


Workforce as of March 31, 2011
Excluding Wholly Owned Subsidiaries Staff

Programs and services are offered at 400 facilities throughout the province, including hospitals, clinics, continuing care facilities, mental health facilities and community health sites. The province also has an extensive network of community-based services designed to assist Albertans maintain and/or improve health status. Service is available by phone through the province's Health Link service.

Alberta Health Services is required to prepare and submit to the Minister of Health and Wellness an annual report in compliance with the Government Accountability Act and the Regional Health Authorities Act. The annual report is provided to the Minister in the form and manner prescribed and is a key public accountability document that reports how Alberta Health Services discharged its legislated responsibilities and any other responsibilities delegated to it by the Minister. The Minister tables the annual report in the Legislative Assembly.

The roles, responsibilities and accountabilities of Alberta Health Services are further described in the *Alberta Health Services Mandate and Roles Document* which was finalized in December 2010.

The legislative responsibilities of Alberta Health Services outlined in Section 5 of the Regional Health Authorities Act are to:

- Assess on an ongoing basis the health needs of Albertans
- Determine priorities in the provision of health services in the Alberta Health Services and allocate resources accordingly
- Ensure that reasonable access to quality health services is provided in and through the Alberta Health Services
- Promote and protect the health of the population in Alberta and work towards the prevention of disease and injury
- Promote the provision of health services in a manner responsive to the needs of individuals and communities and supports the integration of services and facilities in Alberta Health Services

All programs and facilities, whether they are owned and operated by AHS or non-profit organizations or private groups, are operated in compliance with specific pieces of program legislation.

Who We Are

Mission, Vision, Values and Strategic Direction

The **Mission** of Alberta Health Services is:

To provide a patient-focused, quality health system that is accessible and sustainable for all Albertans.

The **Vision** of Alberta Health Services is:

To become the best performing publicly funded health system in Canada.

The four **Values** underpinning achievement of this mission create a shared understanding about how Alberta Health Services staff and physicians relate to each other as well as to patients and the public. These values guide the way services are delivered, define the organization and are part of the strategic foundation. These values include:

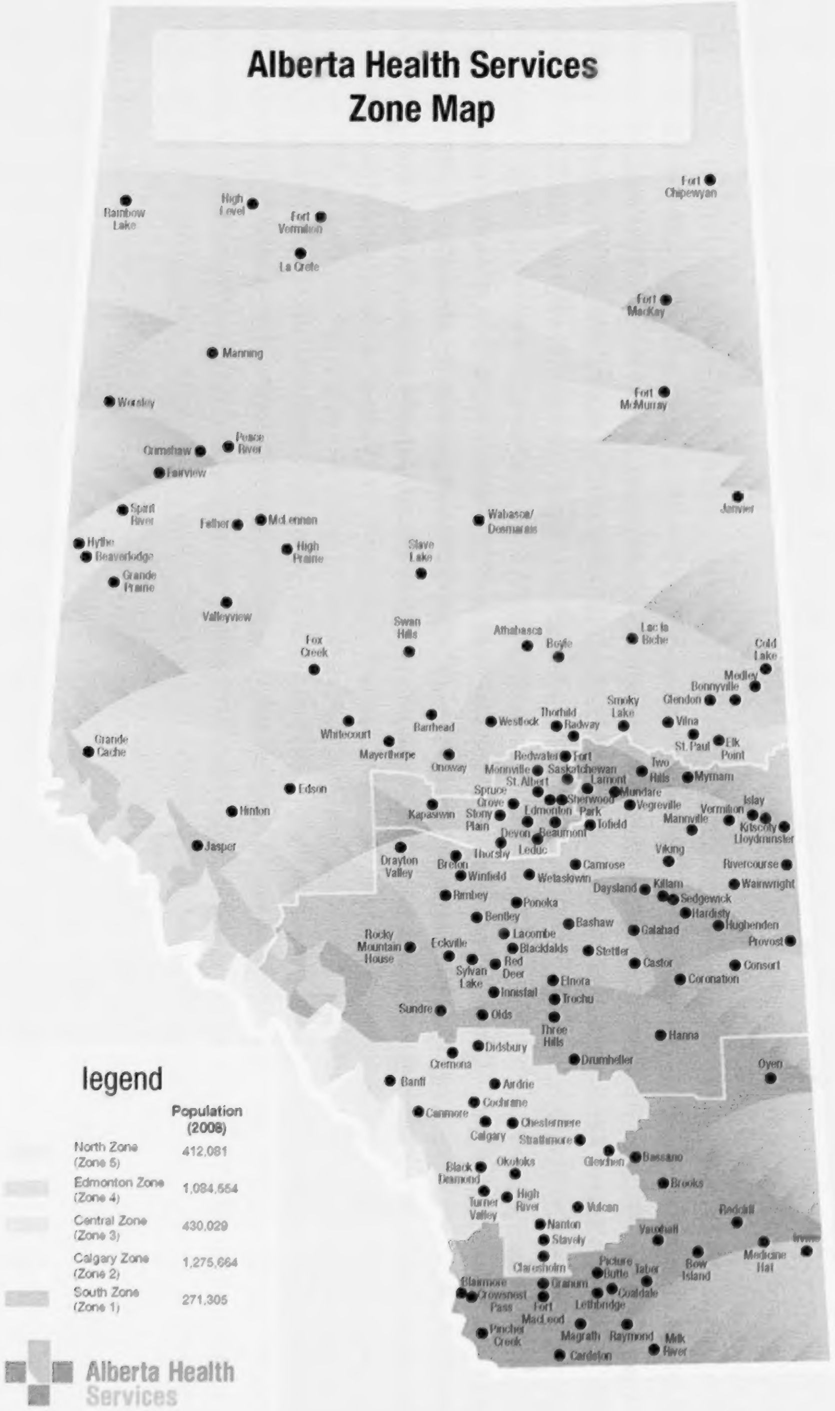
Respect	Accountability	Transparency	Engagement

Our **Strategic Direction** is structured around three key **goals**. Our future success will be measured by the health and wellness of Albertans, their ability to access the system and Alberta Health Services' ability to meet these goals within sustainable budgets.

Quality:	health care services are safe, effective and patient-focused
Access:	appropriate health care services are available
Sustainability:	health care services are provided within available resources both now and into the future

This strategic direction has been further shaped by the joint Alberta Health and Wellness and Alberta Health Services document Becoming the Best: Alberta's 5-Year Health Action Plan 2010 – 2015. All activity within Alberta Health Services is aligned with this 5-Year Action Plan and is intended to support achievement of mutual targets in a variety of areas.

Map


Alberta Health Services
Zone Map
Rainbow Lake
High Level
Fort Vermilion
La Crete
Fort Chipewyan
Fort MacKay
Manning
Worsley
Fort McMurray
Grimshaw
Peace River
Fairview
Spirit River
Falher
McLennan
Wabasca/ Desmarais
Janvier
Hythe
Beaverlodge
High Prairie
Slave Lake
Grande Prairie
Valleyview
Swan Hills
Fox Creek
Athabasca
Boyle
Lac la Biche
Cold Lake
Medley
Bonnyville
Glendon
Smoky Lake
Thorhild
Radway
Westlock
Barrhead
Whitecourt
Mayerthorpe
Vilna
St. Paul
Elk Point
Grande Cache
Onoway
Redwater
Fort Saskatchewan
Morinville
St. Albert
Lamont
Two Hills
Myrnam
Mundare
Sherwood Park
Vegreville
Spruce Grove
Stony Plain
Edmonton
Tofield
Vermilion
Mannville
Islay
Kitscoty
Lloydminster
Edson
Hinton
Kapasiwin
Devon
Beaumont
Leduc
Jasper
Thorsby
Viking
Drayton Valley
Breton
Winfield
Wetaskiwin
Camrose
Rivercourse
Daysland
Killam
Sedgewick
Wainwright
Rimbey
Ponoka
Hardisty
Bentley
Bashaw
Galahad
Hughenden
Lacombe
Provost
Rocky Mountain House
Eckville
Blackfalds
Stettler
Sylvan Lake
Red Deer
Castor
Consort
Elnora
Coronation
Innisfail
Trochu
Sundre
Olds
Three Hills
Hanna
Didsbury
Cremona
Drumheller
Oyen
Banff
Airdrie
Cochrane
Canmore
Chestermere
Calgary
Strathmore
Black Diamond
Okotoks
Gleichen
Bassano
Brooks
Turner Valley
High River
Vulcan
Redcliff
Nanton
Stavely
Vauxhall
Medicine Hat
Irvine
Claresholm
Picture Butte
Taber
Bow Island
Blairmore
Crowsnest Pass
Granum
Fort MacLeod
Coaldale
Lethbridge
Pincher Creek
Magrath
Raymond
Milk River
Cardston
legend
Population (2006)
North Zone (Zone 5) 412,081
Edmonton Zone (Zone 4) 1,084,554
Central Zone (Zone 3) 430,029
Calgary Zone (Zone 2) 1,275,664
South Zone (Zone 1) 271,305
Alberta Health Services

Quick Facts

Alberta Health Services	2009/2010	2010/2011 Preliminary
Primary Care		
Home Care Clients	107,000	112,000
Health Link Calls	1,030,192	758,971[a]
EMS Calls/Events	377,000	377,280
Acute Care		
Emergency Department Visits	1,952,803	1,941,798
Urgent Care Visits	125,916	177,158
Hospital Discharges	362,314	364,021
Births	50,738	49,756
Total Hospital Days	2,511,251	2,545,269
Average Length of Stay (in days)	6.9	7.0
Diagnostic/Specific Procedure		
Total Primary Hip Replacements	3,131	3,156
Total Primary Knee Replacements	4,128	4,395
Cataract Surgery	28,601	33,714
Main Operating Room Activity	239,999	249,997
MRI Exams	165,948	177,422
CT Exams	n/a[b]	333,163
Lab Tests	59,135,200	61,260,258
Cancer Care		
Cancer Patient Visits	510,532	524,420
Cancer Patients Receive Treatment, Care & Support	46,047	46,889
Addiction & Mental Health		
Mental Health Hospital Discharges (acute care sites)	18,395	18,394
Community Treatment Orders (CTO) Issued	10	98

Notes:

a. Health Link Calls high volumes in 2009/2010 were due to H1N1.

b. CT exam count converted to new methodology effective October 1, 2010.

c. As CTO legislation came into effect in January 2010, the 2009/10 numbers reflect only the last quarter. The information reported is based on number of CTO First Issuances. The goal of CTO is to assist individuals in maintaining compliance with treatment for mental disorders while they live in the community to prevent hospitalization.

Bed Numbers

Reported Beds Staffed & In Operation Summary as of March 31st Alberta Health Services Beds by Type

Number of Beds/Spaces	As of March 31, 2010	As of March 31, 2011	Difference	% Change
Hospital - Acute Care	7,762	8,071	309	4.0%
Sub-acute in Auxiliary Hospitals	408	408	0	0.0%
Psychiatric - Standalone Facilities	867	884	17	2.0%
Addiction Treatment	1,338	1,343	5	0.4%
Continuing Care	19,630	20,785	1,155	5.9%
Palliative and Hospice	177	181	4	2.3%
Mental Health Community Beds/Spaces	436	436	0	0.0%
Alberta Total	**30,618**	**32,108**	**1,490**	**4.9%**

Source: AHS Bed Survey as of March 31, 2011; Revised June 09, 2011.

Note: March 31, 2010 bed numbers were adjusted from 2009/2010 Annual Report to reflect the Lloydminster Hospital in Saskatchewan beds reduced to 35 acute care beds from 65 acute care beds to reflect the number of beds utilized by Albertans as well as incorporating other updated information.

Board Governance

Alberta Health Services Board

Tasked with coordinating the delivery of health supports and services across the province, the AHS Board supports the Minister of Health and Wellness' mandate to improve access to care and to create a sustainable health system. The AHS Board reports directly to the Minister.

The following is a list of Board Members who were part of the AHS Board in 2010. Some Board members ceased to be Board members part way through the year and others were appointed as noted.

- Ken Hughes (Chair)
- Catherine Roozen (Vice Chair)
- Jack Ady (May 2008 – Aug 2010)
- Lori Andreachuk (Nov 2008 – Aug 2010)
- Dr. Ray Block (Feb 2011 – present)
- Gord Bontje (Nov 2008 – Nov 2010)
- Teri Lynn Bougie (Nov 2008 – present)
- Jim Clifford (Nov 2008 – Aug 2010)
- Dr. Ruth Collins-Nakai (Feb 2011 – present)
- Strater Crowfoot (Nov 2008 – Mar 2011)
- Tony Franceschini (Nov 2008 – Nov 2010)
- Dr. Kamalesh Gangopadhyay (Oct 2010 – present)
- Linda Hohol (May 2008 – Nov 2010)
- Don Johnson (Feb 2011 – present)
- Dr. Andreas Laupacis (Nov 2008 – Nov 2010)
- John Lehners (May 2008 – present)
- Irene Lewis (May 2008 – present)
- Stephen Lockwood (Oct 2010 – to present)
- Don Sieben (May 2008 – present)
- Dr. Eldon Smith (Feb 2011 – present)
- Sheila Weatherill (Feb 2011 – present)
- Gord Winkel (Nov 2008 – present)

Alberta Health Services Board Committees include: Audit and Finance Committee, Quality & Safety Committee, Governance Committee, Health Advisory Committee, and Human Resources Committee.

Alberta Health Services Board Members completed their first annual assessment from a governance perspective which included the effectiveness of Board Committees. This will now become a standard part of Board assessments and quality improvement.

Accreditation is a requirement for Alberta Health Services. Based on a three year rotating Accreditation schedule, Board and Governance were priorities for the first year which began in 2010. As part of this review, the AHS Board was directly involved in a self assessment through Accreditation Canada including a meeting of Board members with Accreditors to discuss the role of the Board, decision making processes, and accountability.

Health Advisory Councils

Each of the 12 Health Advisory Councils established in 2009/2010 consist of 10 to 15 members, including a Chair and will each represent a different geographical area:

Health Advisory Councils	Geographical Area
1. True North Health Advisory Council	La Crete, High Level & Area
2. Peace Health Advisory Council	Grande Prairie & Area
3. Lesser Slave Lake Health Advisory Council	Slave Lake, High Prairie & Area
4. Wood Buffalo Health Advisory Council	Fort McMurray & Area
5. Lakeland Communities Health Advisory Council	Lac La Biche, Cold Lake & Area
6. Tamarack Health Advisory Council	Hinton, Edson & Area
7. Greater Edmonton Health Advisory Council	Edmonton & Area
8. Yellowhead East Health Advisory Council	Vegreville, Lloydminster & Area
9. David Thompson Health Advisory Council	Red Deer & Area
10. Prairie Mountain Health Advisory Council	Calgary & Area
11. Palliser Triangle Health Advisory Council	Medicine Hat & Area
12. Oldman River Health Advisory Council	Lethbridge & Area

The mandate of the Health Advisory Councils is to support AHS in achieving its strategies by engaging residents and providing advice and feedback from a local perspective on what is working well in the health care system and areas in need of improvement in communities across the province. All council members will be appointed by the AHS Board.

During their first year of operation, the councils were involved in developmental initiatives including the selection of a name to best represent the geographical area each council serves, nominating a Chair and Vice Chair for each respective council, producing an annual work plan and acting on strategies that fulfill their mandate as a council. Many council members attended the inaugural province-wide Health Advisory Council meeting, and are in the process of producing 2010-2011 Annual Reports to highlight the work undertaken and their accomplishments during the year.

The councils provide feedback on several fronts for Alberta Health Services which assist in planning processes (current and future) and key areas of strategy development. Several AHS planning initiatives were reviewed by councils and advice was provided to support the work. Examples include Community and Rural Health Planning, the 21-Day Provincial Menu, the Accreditation process partner consultation, Alberta Health Services Annual Health Plan, Strategic Scenarios 2030 "Driving Forces Workshops" and considerable involvement in the Alberta Health Act province wide consultation sessions lead by Mr. Fred Horne, Co-Chair Ministers Advisory Committee on Health, MLA Edmonton-Rutherford.

Infrastructure to support council operation was established during 2010/2011 including a webpage for each council on the AHS website, individual council email addresses, daily communications and background information on emerging news or issues, attendance at Alberta Health Services Board engagement events, two recruitment campaigns to fill vacant positions, and a member satisfaction survey.

The role of the councils has been significantly strengthened during this foundational year with the Alberta Health Services Board meeting regularly with council Chairs, quarterly conference calls with the Board Chair, Chair of the Health Advisory Council of the Board and President & CEO, and increased Board member attendance at council meetings.

In the upcoming year, the councils will increase the number of community consultations held with Albertans to provide AHS with more feedback on the local perspective surrounding health care delivery in communities across the province.

2010/2011 Organizational Structure

The President & Chief Executive Officer of AHS leads a staff of 92,000 caring and dedicated individuals who make up the AHS workforce. In this role, the President & Chief Executive Officer is leading health services through transformational change, shaping the future for AHS to allow achievement of the goals of access, quality and sustainability. He is also responsible to the Board for the organization's day-to-day operations.

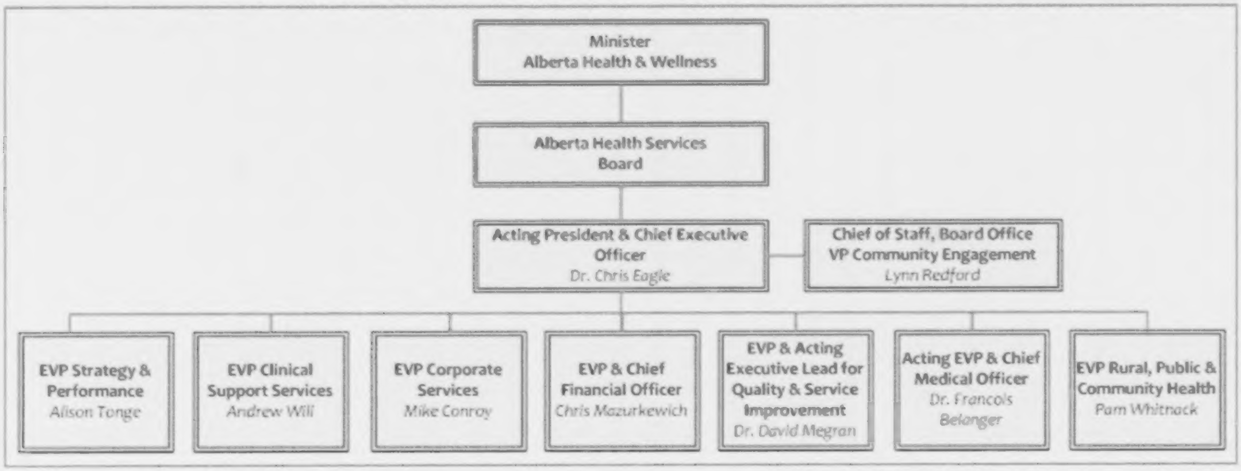
With leaders and staff in the organization, Alberta Health Services will build a culture that:

- exemplifies our values of respect, accountability, transparency and engagement
- takes a provincial perspective on issues
- ensures good ideas developed in one part of the province are shared across the province

Our organizational structure is arranged into the following areas:

- Quality and Service Improvement
- Strategy and Performance
- Rural, Public and Community Health
- Finance
- Corporate Services
- Chief Medical Officer
- Clinical Support Services

Each area is led by a member of the executive team, all reporting directly to the President & Chief Executive Officer.


Minister
Alberta Health & Wellness
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Dr. Francois Belanger
EVP Rural, Public & Community Health
Pam Whitnack

Dr. Stephen Duckett served as President and CEO of Alberta Health Services from April 2009 to November 2010. He was the organization's first CEO.

Dr. Chris Eagle was named as Acting President and CEO in November 2010. Dr. Eagle was named the President and Chief Executive Officer of Alberta Health Services on April 15, 2011. (This organization structure is currently being realigned.)

Strategic Initiatives, Accomplishments and Results

The 2010/2011 year was challenging from many perspectives, however much was accomplished. Work continued to be required to build the foundation for operating as one health system and capitalize on the opportunities afforded through merging organizations. Building on the success of 2009/2010 in slowing the cost growth in our health system, continued focus was placed on improving sustainability. In particular, historic growth in the acute care sector costs has been rebalanced with investments in community-based alternatives, such as accommodations and supports for seniors.

AHS is committed to becoming a high performing organization which means that, not only should we reduce cost, but we must improve quality and access. Our 5-year Health Action Plan (Becoming the Best) has established performance goals and a road map of improvements toward building this high performing system. We are at the beginning steps on this road to high performance and we now have clear direction and many strategic efforts in place to deliver on our goals.

The section that follows identifies the many initiatives underway and shows some early results in our plan. Some very positive steps have been recently initiated including the provincial-wide work related to Emergency Care and the improvements in Continuing Care capacity that have been implemented in the later part of this year.

While improvements have been made, many of the performance measures related to access currently have not yet achieved the target. It should be noted that the targets were deliberately set to be challenging to attain, and they do not fully reflect all the positive advancements that have been made over the past year. We will build on these advancements and improvement of targets remains a high priority for the upcoming year. We anticipate the results will improve with time, as our transformation in pathways of care take hold; as we build capacity in our communities; as we work with our partners in primary care; and as we focus our efforts across the care continuum.

1.0 Staying Healthy/Improving Population Health

Our foundation to improve the health of all Albertans is to focus on health promotion and reduce health inequities. Enabling people to stay well and to minimize their need to access health services will improve both the quality of life for Albertans and enable the system to be more sustainable. This focus on health promotion and wellness underlies all of what we do across the continuum of care within Alberta Health Services and requires full partnership with the public, government and a variety of stakeholders.

Health promotion, disease and injury prevention will be addressed in a collaborative manner with Alberta Health and Wellness. Some of the preliminary priority areas are:

- Healthy development (birth outcomes, screening and early detection)
- Cancer and chronic disease prevention (healthy weights, tobacco use, screening)
- Injury prevention (suicide, transportation, falls)
- Addiction prevention and mental health promotion (resiliency, stigma and discrimination, alcohol consumption, illicit drug use, gambling); and
- Health-promoting social and physical environments (health disparities, built environments, social environments)

Priorities for Action: Population Health

Improve population health through integrating health promotion and disease and injury prevention programs with other health care delivery services and better co-ordination between health and other government and municipal sectors.

Actions (in collaboration with AHW)	**Progress/Results**
Screening Programs Complete the breast cancer screening program application development project; initiate cervical and colorectal cancer screening program database development project. Enhance collaboration with Primary Care Networks, Zones and other services along the screening pathways; Coordinate the various population based screening program components. Social marketing strategy for breast and cervical cancer screening developed; Culturally appropriate and translated public educational resources; Updated education materials and ongoing health care professional education and client correspondence.	• In September 2010, culturally appropriate and translated public educational resources on cancer screening were developed and distributed over 143,000 resources to health care providers and the public. • In December 2010, the Cancer Screening Community Action Strategy was developed to increase cancer screening participation rates for un/under-screened groups at the community level. • Cancer Screening mobile units provided screening mammography services to over 18,600 clients in 102 rural communities, including First Nations communities. • Screening Programs provided correspondence to 486,860 people in target populations for Breast, Cervical and Colorectal cancer screening. • Approval has been received from the Minister's Office in support of obtaining corporate sponsorship to provide incentives for women to participate in a Breast Cancer/Cervical Cancer Social Marketing Campaign. • Established a plan to move forward with the enhancement of Alberta Breast Cancer Screening Program (ABCSP) software application with a release date of September 2011. • Provided Patient Care Network (PCN) pilot to enhanced correspondence and implemented to increase participation in cervical screening. • Implementation began on a province-wide colorectal cancer screening program. • Phase 1 of Enhanced Participation in Screening Project is completed which compared the standard and customized cancer screening invitation letters within a PCN population panel to increase screening rates. This approach proved effective in increasing screening uptake. The final report will be completed by June 2011. • Phase 2 of EPICS will focus on overcoming the barriers identified in Phase 1 to allow for expansion across Primary Care Networks. The focus for this phase will be optimizing the use of the electronic medical record into the patient reminder system. • Alberta Cervical Cancer Screening program (ACCSP) application is currently being upgraded to allow screening correspondence to be expanded to the northern half of the province. Completion is expected by December 2011. • Electronic, synoptic colonoscopy reporting system has been successfully implemented in 7 rural sites across the province. This project enabled nearly 80% of the endoscopy rural sites in Alberta to electronically document, archive, share and review colonoscopy procedures and resulting pathology reports.

Strategic Initiatives, Accomplishments and Performance Results

1.0 Staying Healthy/Improving Population Health

Priorities for Action: **Population Health**

Improve population health through integrating health promotion and disease and injury prevention programs with other health care delivery services and better co-ordination between health and other government and municipal sectors.

Actions (in collaboration with AHW)	Progress/Results
Chronic Disease Prevention Completion of Provincial Oral Health Strategic Plan.	• The Oral Health Action Plan was approved in October 2010.
Injury Prevention Identify key areas to align and implement suicide prevention work across AHS. Complete comprehensive evaluation of the Report Impaired Drivers campaign.	• Completed Quick Reference Summary of all seminal reports, strategic plans, frameworks, etc. which provides specific direction for suicide prevention planning and service implementation. • Completed three Positive Futures funded suicide prevention projects and completed the recommendation on how to proceed with project revisions and allocations. • Completed consultation on draft policy and procedures suite for acute Suicide Prevention. • The Report Impaired Driving Campaign is a public awareness strategy to encourage members of the public to report suspected impaired driving through the 911 system. Working in collaboration with MADD Canada, Calgary Police Service and the City of Calgary; AHS led the comprehensive evaluation of the initiative, including compilation and analysis of statistical and public perception data gathered before and following launch of the campaign.
Healthy Development Develop strategy to implement 'A Million Messages' on a provincial basis.	• 'A Million Messages' program across AHS has been initiated through the coordinating committee. 'A Million Messages' is a comprehensive plan to standardize the message given to parents during every contact with a Community Health Nurse. Each message is simple, consistent, routine, and targets an issue that affects children at the appropriate stage in their development. • Web-based supports for program implementation is in process of transitioning to the AHS website.
Newborn Metabolic Screening:	• Newborn Metabolic Screening Action Plan (operational model, business plan, implementation and evaluation plan) for a comprehensive, system-wide newborn metabolic screening program that achieves the standards set forth in 2010 Alberta Health and Wellness Policy Document was approved in December 2010 and implementation began in January 2011 using a staged approach.
Preschool Developmental Screening:	• Alberta Health and Wellness (AHW) initiated developing a business case for a comprehensive approach to early childhood screening (including universal newborn hearing, growth, vision and developmental screening). The Alberta Health Services work is delayed pending further policy direction from AHW.
Safe Infant Sleep:	• Evidence-based key messages for 'Safe Infant Sleep' were established.
Comprehensive School Health (CSH):	• Internal CSH Steering Committee established and provincial strategic direction to be drafted in 2011/2012. Healthy Weights provincial work plan implemented.
Addiction and Mental Health	
Complete implementation of AHS Tobacco and Smoke Free Environments policy.	• AHS Tobacco and Smoke Free Environments Policy was approved on January 27, 2011 to prohibit the use of tobacco products and prevent exposure to second-hand at AHS.
Finalize development of provincial tobacco cessation framework for AHS.	• Provincial Tobacco Cessation Advisory Committee was established; draft tobacco cessation framework was completed to be finalized in June 2011.
Coaching/Knowledge Exchange Community of Practice in place for zone addiction prevention staff.	• Two Coaching and Knowledge Exchange (CAKE) events were held in the past year – November 2010 and April 2011. Over 70 staff and 35 sites participated. Topics covered were Tobacco & Alcohol Youth Experience Survey 2008; community addiction prevention grants; Coalition Connect event; two projects with post secondary institutions; tobacco use in a middle school and foster parent support. Both CAKE events were well received by attendees.
Tobacco cessation health professional training standardized.	• Tobacco Reduction and Cessation (TRaC) training manual completed and being used as a primary tool for staff training on tobacco cessation. Worked with Pharmacy Services on revisions to the pharmacology section of the training.
Determine how AHS Mental Health First Aid program will be implemented.	• This program was successfully transferred to the Mental Health Commission of Canada in 2010.

1.0 Staying Healthy/Improving Population Health

Priorities for Action: Population Health

Improve population health through integrating health promotion and disease and injury prevention programs with other health care delivery services and better co-ordination between health and other government and municipal sectors.

Actions (in collaboration with AHW)	Progress/Results
Healthy Public Policy Complete Strategy for the Built Environment for Health Promotion, Disease & Injury Prevention (HPDIP) and develop framework for reducing disparities (that includes the social determinants of health).	• AHS Integrated Steering Committee on Health Disparities established and framework currently under development.
Environmental Public Health Investigate and plan for a new information system province wide for Environmental Public Health.	• Continued work with AHW to determine next steps on joint development of Information System. In the interim, continued work with Information Technology and Environmental Public Health on moving to a common system province-wide.
Develop strategies for continued improvement in restaurant inspection rate.	• Restaurant inspection rate increased to 88% province-wide for calendar year 2010. • Food safety review completed in May 2010 and then Food Safety Implementation Plan submitted to Executive in January 2011 pending approval.
Aboriginal Health/Reducing Disparities Create partnerships with Aboriginal Communities to begin to address health issues and concerns. Develop and present cross cultural education forums. Develop a strategic plan to assist Aboriginal People to improve their health. Complete a provincial inventory of existing primary care/ Chronic Disease Management (CDM) services and supports to determine what exists for diverse and vulnerable populations, what are the strengths, gaps and needs, and what programming and support are needed. Equip primary care and CDM teams with knowledge, skills and tools to provide diversity-competent services. This includes working with educational institutions, public and organizations serving the vulnerable populations with a goal of harm reduction for all populations.	*Diverse Population Plan:* • In partnerships with diverse communities, a provincial working group and multiple sub-working groups have identified service gaps and programming needs of vulnerable and diverse populations. A review and report of best and promising Primary Care/Chronic Disease Management (CDM) practices for diverse and vulnerable populations has been completed. *Diverse Populations Strategy work includes:* • A Diverse Population Working Group comprising of AHS zones, external stakeholders and five sub-working groups (ethno-cultural, Aboriginal, Hutterite/ Mennonites, francophone and homeless) was established. • Partnerships with multiple stakeholders: Francophone, Aboriginal, Homeless and Health Canada were established. • Consideration of diverse populations' needs was incorporated into the provincial, Obesity, Diabetes Quality Improvement plans and Integrated Community-based Chronic Disease Management model. • Mapping of population diversity in Alberta and distribution at AHS zones developed to guide the service planning. • Developing provincial Primary Care/Chronic Disease Management models for diverse populations; incorporate the needs of the diverse populations into Initiative Proposal for implementation of integrated community-based CDM model.

Summary: In conjunction with AHW, numerous initiatives have been implemented in the areas of screening programs, chronic disease prevention, injury prevention, healthy development, addiction and mental health, healthy public policy, environmental public health and aboriginal health/reducing disparities. In addition to improving quality of life, these initiatives will help to increase life expectancy and reduce potential years of life lost.

Over the next five years, through the implementation of these initiatives, it is anticipated that disparities in life expectancy throughout various AHS zones in the province will decrease, and that there will be an increase in life expectancy among First Nations populations.

1.0 Staying Healthy/Improving Population Health

Performance Measure	2005	2006	2007	2008	2009	2010	2010/2011 Targets
Life Expectancy: Provincial The number of years a person would be expected to live, starting at birth, on the basis of mortality statistics. Both sexes combined.	79.0	79.5	80.2	79.6	81.0	81.6	Over the next five years, Alberta Health & Wellness expects that life expectancy would increase in a manner consistent with the Canadian average, with the goal being to be above the national average of 80.7 years (2005/2007 per Statistics Canada).
South Zone	79.0	79.5	80.2	79.6	80.1	80.3	There is an expectation that the disparities in life expectancy throughout various zones in the province would decrease over the next five years, with the goal of having life expectancy in all geographical zones above the Canadian average.
Calgary Zone	81.6	81.7	81.7	81.9	82.4	82.9	
Central Zone	78.6	79.4	79.3	79.5	80.1	80.7	
Edmonton Zone	80.3	80.5	80.8	80.8	81.0	81.8	
North Zone	77.8	78.1	78.6	78.3	79.3	79.8	
First Nations	69.2	69.8	69.2	68.0	69.3	70.4	There is an expectation that there will be an increase in life expectancy among First Nations populations over the next five years.
Non-First Nations	80.5	80.8	81.0	81.0	81.5	82.0	
Potential Years of Life Lost per 1,000 Population: The total number of years not lived by an individual who died before their 75th birthday.							
Total Population	53.1	50.8	50.5	50.3	47.3	44.8	There is an expectation that Potential Years of Life Lost will be monitored, and that improvements will be seen in PYLL over the next five years.
Females	38.9	38.0	38.4	37.7	37.1	33.9	
Males	67.2	63.5	62.6	62.8	57.4	55.5	

Source: Alberta Health & Wellness

2.0 TIP - Building a Primary Care Foundation

Patient-centred, coordinated and comprehensive healthcare provided through a robust primary care system has been shown to improve the health of the population, and to increase the efficiency of healthcare delivery.

With an aging population and chronic disease on the rise, it is imperative that we offer Albertans access to the best primary care system, and in turn, the best opportunity to maintain good health and access to the services they need, when they need them.

Another key issue that needs to be addressed is supporting individuals with addiction and mental health issues. Improving both prevention and access to supports and services in this area are critical.

Priorities for Action: Prevention

Improving Immunization Rates.

Actions (in collaboration with AHW)	Progress/Results
Influenza Immunization In conjunction with zone operations, develop a seasonal and pandemic Immunization plan to be included in pandemic plan.	• A number of steps were taken to enhance immunization coverage for the seniors and child population during the 2010/11 influenza season, including the engagement of a range of community partners who offered the vaccine (pharmacies and physician offices), the establishment of targeted clinics for seniors, the administration of vaccine for home-bound seniors, as well as the administration of vaccine when children presented for routine immunizations in child health clinics. • In addition, the first in a series of planning meetings for the 2011/12 season was held in February 2011 with representatives from AHS and Alberta Health and Wellness, along with physicians, pharmacists and other health care providers to discuss strategies to optimize immunization coverage next season. • Additional teleconference discussion sessions were also held with small groups of physicians in February 2011 to elicit feedback and plan for influenza immunization in 2011/2012 season. • Plans have been completed to enable timely reporting of immunization coverage. This will involve obtaining coverage rates from each zone-based immunization database, as opposed to the provincial system which continues to experience technical issues.

Summary: As noted below, there is demonstrated improvement from previous years. However, continued focus is required in the area of data integrity and social marketing. Methods of data collection have been inconsistent in previous years and rates are not directly comparable. AHS is working with AHW to standardize data collection and reporting of this indicator.

There are pockets of low immunization across the province. Specific strategies need to be developed to increase the immunization rate closer to the target by identifying why some children are not immunized, and to increase access and modify existing immunization delivery programs to best suit the local population.

New processes to improve on the timeliness and frequency of immunization reporting are slated to come into effect later in 2011. Development of the 2011/2012 seasonal influenza immunization campaign will continue over the coming months under Steering Committee leadership.

Performance Measure	2008/2009	2009/2010	2010/2011	2010/2011 Targets
Rates of seasonal influenza immunization by age group:				
Adults aged 65 and older	58%	56%	59%	75%
Children aged 6 to 23 months	43%	16%	27%	75%

Performance Measure	2008/2009	2009/2010	2010/2011	2010/2011 Targets
Rates of seasonal influenza immunization by age group:		***Data not available at time of report for 2009 to current***		
Diphtheria/ Tetanus/ acellular Pertussis, Polio, Hib	80%	84%	84%	95%
Measles/Mumps/Rubella	91%	89%	89%	95%

Source: Alberta Health & Wellness and Alberta Health Services

2.0 TIP - Building a Primary Care Foundation

Priorities for Action: Primary Health Care

Apply and advance a patient-focused model of primary health care that offers care in the community, and provides a team-based provider approach.

Actions (in collaboration with AHW)	Progress/Results
Complete a Primary Health Care Strategy & Primary Care model.	Draft Primary Care Model was developed which included Funding Models, Referral and Speciality Linkages, Infrastructure, Inter-professional teams, Information Technology /Information Management (IT/IM), Quality Improvement and Governance. This model development involved a significant amount of engagement.

Summary: Significant improvement is noted and will continue. AHS Zones are actively recruiting new physicians to form PCNs or to join existing PCNs. New PCNs have also been established recently in Grande Prairie (Oct. 2010), Lloydminster (Jan. 2011) and Wainwright (Apr. 2011), with five more prospective PCNs currently at the Letter of Intent stage. In addition, work is ongoing to increase enrolment of specific populations (e.g. palliative patients and new mothers with babies).

Work is ongoing to recruit patients not yet attached to a physician. In addition, all partners will continue to work collaboratively to improve efficiency, patient and provider satisfaction, and increased PCN participation within the framework of a primary care model that supports physicians, teams and best practice.

Alberta Health Services is working to apply and advance a patient-focused model of primary health care that offers care in the community, and provides a team-based health care provider approach.

Performance Measure	April 2008	April 2009	April 2010	April 2011	2010/2011 Targets
Percent of Albertans attached to a primary healthcare provider in a Primary Care Network.	50%	59%	64%	72%	75%

Sources: Alberta Health & Wellness; Apr 2010 figure is a preliminary calculation from AHS.

2.0 TIP - Building a Primary Care Foundation

Priorities for Action: Primary Care

Reduce the number of hospital visits and admissions that could have potentially been prevented through the provision of appropriate non-hospital health services.

Actions (in collaboration with AHW)	Progress/Results
Develop a provincial strategy to reduce diabetes admissions by one third. Implementation to begin April 2011. Develop and implement an action plan to reduce obesity.	• Provincial Diabetes Plan developed by March 2011. • Created a Provincial Diabetes Working Group in January 2011 to identify gaps for diabetes and priorities within each of the five zones using AHS Improvement Way (AIW) principles and methodology as an initial framework. Zone workshops were conducted to identify and prioritize opportunities and action plans for short-term improvements within current resources. • Provincial Obesity Strategy developed December 2010, implementation plans underway.
Integrate chronic disease registries to identify populations with chronic diseases, assess uptake of guidelines, and improve the management of chronic diseases. **Access to Primary and Specialty Care** In collaboration with Alberta Health and Wellness, develop a provincial model that will facilitate access from primary to specialty care.	• Implemented the Chronic Disease Management Registry/E-referral/Interactive Continuity of Care Record: Information system to enable integrated care pathways. • Business case developed in March 2011 to expand Stanford Self Management Model to ensure equal access across the province. • Established a Joint Alberta Health & Wellness (AHW) / Alberta Health Services (AHS) Policy Health System Patient Navigation Committee by AHW in fall 2010 to oversee the work lead by the consultants. Through a consultation process with members of the steering committee and numerous focus groups from across the continuum of care, a draft model and policy document is in development.
Enhance the role of Health Link Alberta, primary care services, Urgent Care Centres and other alternatives in order to improve 24/7 access to appropriate services, in the appropriate time and place.	• Completed HealthLink Alberta Marketing Campaign including Urgent Care Options. • Implementation of a new schedule for Nursing and Information and Referral staff is underway. • Work has progressed with Zones, Health Link and Communications for easier access, targeting one number for each zone to access Continuing Care services.

Summary: As noted below, performance remains better than the target. A business case has been submitted for additional staffing support within the South, Central and North Zones (where targets are not being met) to enhance self-management supports and patient participation in community based programming. A plan for technology upgrades continues its development to assist with improving the Health Link Alberta wait time target.

AHS and Patient Care Networks (PCNs) continue to work on decreasing hospital admissions and Emergency visits by focusing on chronic disease management and prevention, maximizing the use of inter-professional teams (e.g. social workers and mental health providers), and also ensuring that hospital flow and transitions with the community are appropriate.

Performance Measure	2008/2009	2009/2010	2010/2011	2010/2011 Targets
Ambulatory Care Sensitive Conditions: Rate of hospital admissions for health conditions that may be prevented or managed by appropriate primary health care.	298	285	281	304
Family Practice Sensitive Conditions: Percent of emergency department or urgent care visits for health conditions that may be appropriately managed at a family physician's office.	28%	27.4%	27.5%	27%

Sources: AHS Discharge Abstract Database and Provincial Ambulatory (ED/Urgent Care) Abstract Data

Performance Measure	2008/2009	2009/2010	2010/2011	2010/2011 Targets
Health Link Wait Time: Percentage of calls to Health Link Alberta that are answered within two minutes.	46%	66%	78%	80% in 2 minutes

Sources: Health Link Alberta, Nortel Contact Centre Management 6.0

2.0 TIP - Building a Primary Care Foundation

Priorities for Action: Mental Health and Addictions

Improve the availability and accessibility of mental health and addiction services for Albertans in community settings, especially services for children and youth.

Actions (in collaboration with AHW)	**Progress/Results**
In collaboration with Alberta Health & Wellness (AHW), develop a comprehensive provincial action plan for addiction and mental health services. Develop a provincial sourcing strategy for addiction and mental health contracted services.	• Completed alignment of mental health care pathways with primary care provincial initiatives. • Disseminated, implemented and monitored provincial pathways for mental health (depression) among Primary Care Networks (PCN) and primary care zone leads.
Action all priorities from the Addiction and Mental Health Strategic Plan and priorities endorsed by the Addiction and Mental Health Clinical Network: • Collaborative pilot project with Calgary Shared Care beginning May 2010 to evaluate the process for development and implementation of a primary care clinical care pathway for depression. • Adopt a concurrent capable approach for addiction and mental health services through development and implementation of standardized screening and assessment. • Framework for clinical development and support with identified core competencies and required professional development systems. • Coordination of work in acute care with Alternate Level of Care (ALC) 2010 plan completed jointly with zones and recommendations to adopt Canadian Institute for Health Information (CIHI) definition of ALC across services to improve monitoring and reporting.	**Action all priorities from the Addiction and Mental Health Strategic Plan:** • Linked depression care pathways to provincial PCN practice. • Maintained involvement in system-wide case management initiative and provincial taskforce on Addictions and Mental Health. • Completed and piloted clinical pathway for adult depression in primary care. • New acute mental health beds (14) opened at Villa Caritas in January 2011. Transition mental health beds (30) were delayed in opening at Villa Caritas due to recruitment challenges. 12 detox beds opened in February 2011 at the Addiction Recovery Centre in Edmonton.
Evaluate key actions from 2009-2010, including Community Treatment Orders (CTOs) and Safe Communities initiatives.	
Continue to implement the Children's Mental Health Plan for Alberta. All 23 actions will be underway across all zones with evaluation mechanisms in place.	**Continue to implementation of the Children's Mental Health Plan:** • Implemented access standards for children's mental health services for emergent care, urgent care and scheduled visits. • Increased access to basic and specialized children's mental health services for those children and youth who reside in rural and remote areas across the province. • Child, Adolescent and Family Mental Health have been contracted to provide eight specialized inpatient mental health beds and remain at full capacity. • Enhanced and strengthened collaboration and co-ordination of services for children and youth during their transition from psychiatric inpatient care to the community, including family and school support. • Increased number of mental health consultants on pediatric units in the Calgary and Edmonton Zone.
Implement the In Roads program to improve access to screening, assessment, referral, early intervention and treatment services for youth and young adults (12 to 24 years) who are at risk for, or have developed a substance use problem. Programming to commence May 2010 at three sites (Edmonton, Red Deer and Calgary).	**Implement the In Roads program:** • Established partnerships between AHS and stakeholder organizations. • Implemented mentoring of service providers and over 60 staff in 19 organizations in Edmonton, Red Deer and Calgary. • Conducted presentations / workshops, developed resource materials and approved clinical screening tools.
Increase the access and quality of addiction and mental health services (assessment, treatment and transition) provided within Alberta correctional and remand centres.	**Increase the access and quality of addiction and mental health services:** • Recruited 20 of 42 Safe Communities addiction and mental health staff to provincial corrections facilities. • Developed training materials for correctional staff to enhance their understanding and awareness of addiction and mental health issues amongst the offender population.

Summary: Significant work has been implemented to improve addiction and mental health delivery systems. Efforts have been focused at Zones which remain below target for the performance measure related to children's mental health services access. Edmonton Zone: implementation of coordinated regional intake and redevelopment of intake processes to ensure screening assessments take place within two-three working days. Edmonton and North Zones: increase in mental health therapy positions to reduce wait times. Calgary Zone: installation of a triage nurse in the Pediatric Behavioral Developmental Clinic to streamline referrals to the appropriate discipline and change in business processes to reduce the time between receipt of referral and assignment to the receiving clinic.

2.0 TIP - Building a Primary Care Foundation

Performance Measure	2008/2009	2010/2011	2010/2011 Targets
Access to Children's Mental Health Services:			
Percent of children aged 0 to 17 years receiving scheduled mental health treatment within 30 days.	Not Available Prior to AHS	75%	85%
Percent of children aged 0 to 17 years receiving emergent, urgent and scheduled mental health treatment within 30 days.	78%	80%	85%

Source: AHS Mental Health Services

3.0 TIP - Improving Access, Reducing Wait Times

Timely access supports good clinical outcomes as it reduces the risk of complications due to further deterioration of health, unnecessary investigations and admissions, and the burden on families and other supports.

The development of provincial standards for clinical practice and wait times will assist in stabilizing and improving access, quality, and the sustainability of care.

Development of access standards and programs that decrease wait times across the province will promote intra-provincial equity.

Priorities for Action: Access to Surgery

Reduce the wait time for **surgical** procedures.

Actions	Progress/Results
Two-stage surgical blitz that will result in approximately 4,500 additional surgeries. Improving quality through better access to surgery supported by innovations including: • Surgical networks – provincial block booking of operating rooms. • Bone and joint central intake model and practice standards. • Cardiac surgery central intake model roll out. • Finalize the standardization of cardiac wait time measurements for Calgary and Edmonton. • Improve utilization of Pre-Op Assessment Clinic.	Completed 4,296 net new surgical cases by March 31, 2011. **Bone & Joint Clinical Network Accomplishments:** • Established four interdisciplinary working groups with membership from across Alberta to develop and lead implementation of work plans to address key priority areas. • Achieved consensus on wait times definitions for hip and knee arthroplasty across the care continuum. • Launched a hip and knee arthroplasty improvement collaborative with clinical teams at 12 AHS sites that will reduce hospital length of stay, wait times and improve quality and safety. • Developed guidelines for MRI use for acute knee injuries. • Completed an analysis of fractured-hip care pathways in use in Alberta. • Completed an inventory of arthritis services and programs in Alberta and consultations with clinicians involved in arthritis care. • Collaborating in a research study that will assess a web-based referral and triage system that will track waiting times along the care continuum in "real time" for hip and knee arthroplasty patients. The proof of concept will be pilot tested with assessment clinics and primary care in Camrose, Medicine Hat and Calgary. **Surgery Clinical Network Accomplishments:** • Approved draft definitions for surgery wait times in collaboration with the work completed by the Bone and Joint Clinical Network. • Completed a snapshot inventory of all operating rooms in AHS and Covenant Health hospitals. • Completed a preliminary analysis of available surgery activity data. • Developed prioritization principles for access to cancer surgery. • Approved a model for health technology assessment and innovation for surgery, including a recommended approach to evaluating innovative technologies and approaches to surgical care. **Cardiac Clinical Network Accomplishments:** • Physician Peer review process enhanced. • Developed and implemented a process to increase surgeon awareness of patients on waiting list and length of time waiting alerts for patients nearing access benchmarks. • Review and re-engineer Referral and Triage process for non-urgent Coronary artery bypass surgery (CABG) patient to assist in the improvement of wait times. • Central Intake process for Urgent and Semi-Urgent continues. • Exploring nurse navigation role to follow patient from referral to surgery in Calgary and optimizing role in Edmonton. • Standardized method of calculating wait times between Edmonton and Calgary completed. • Involvement continues with AHS Wait Time's Measurement and Management group to ensure alignment with provincial standards which will enhance the ability to report, measure and manage wait times. • Cardiovascular Process Improvement project planned to review each part of the patient journey. • Monitor the utilization of existing OR capacity to ensure ongoing maximum efficiency of current allotment and explore possibility of increasing number of cases and alternate OR capacity/space.

3.0 TIP - Improving Access, Reducing Wait Times

Summary: As demonstrated below, improvements have been made in CABG wait times but targets have not been achieved. A computerized "flagging" system was implemented to identify cardiac patients who are close to exceeding the allowable wait time in their applicable urgency category. A clinical assessment is then made to ensure patient safety. As well, a process was implemented for daily triage of urgent and semi-urgent cases based on patient needs and operating room availability.

A number of initiatives have been introduced to reduce wait times for Hip, Knee, Cataracts and Other Surgeries which has demonstrated improvement in Q4. We will build on this improvement going forward. A new central intake process has been established in all five zones. A new orthopedic surgery centre with 4 new operating rooms opened in Edmonton. The provincial Hip and Knee Replacement Transformational Improvement Program (TIP) continues with a view to reducing wait times and length of stay. Cataract surgery volumes continue to be increased to deal with the wait lists and wait times.

Province-wide Access to Surgery: The maximum time that nine out of ten people will wait (in weeks) from decision to treat to treatment.

Performance Measure	2009/2010	2010/2011	2010/2011 Targets
Wait Time for Cardiac Surgery: The maximum time that nine out of ten people will wait (in weeks) from decision to treat to treatment, for: Coronary artery bypass surgery (CABG), by urgency level:			
Urgency I - Urgent	2.4 weeks	2.1 weeks	1.5 weeks
Urgency II – Semi Urgent	7 weeks	6.4 weeks	5 weeks
Urgency III - Scheduled	31 weeks	24 weeks	15 weeks

Source: AHS Open Heart Waitlist Database (Edmonton), VELOS, APPROACH and OR data from ORIS, the OR database (Calgary)

Performance Measure	2009/2010	2010/2011	2010/2011 Targets
Wait Time for Hip Replacement Surgery:	36.4 weeks	39.4 weeks	28 weeks
Wait Time for Knee Replacement Surgery:	49.1 weeks	49.1 weeks	42 weeks

Source: AHS, DIMR from Site Surgery Wait List and Surgical Databases

Performance Measure	2009/2010	2010/2011	2010/2011 Targets
Wait Time for Cataract Surgery:	41 weeks	46.9 weeks	36 weeks
Wait Time for all other Scheduled Surgery:	24.6 weeks	25.7 weeks	Confirm baseline & definition

Source: Alberta Health & Wellness

3.0 TIP - Improving Access, Reducing Wait Times

Priorities for Action: Cancer Care

Increase access in the treatment of Cancer.

Actions	Progress/Results
Develop a provincial strategy for Cancer Care.	• Collaborating with AHW to develop a provincial plan for cancer that considers immediate and future needs for treatment, specialists, and other resources.
Open new radiation sites in Lethbridge and Red Deer.	• New Lethbridge Cancer Centre opened in June 2010. • The Lethbridge Cancer Centre will do more than minimize travel for cancer patients in southern Alberta. The facility has been designed and equipped to provide the highest-quality care in a patient-friendly setting. In October 2010, the Cancer Centre was renamed the Jack Ady Cancer Centre. • A CT scanner is on site for planning radiation treatment. • Two linear accelerators are located in the province's first doorless radiation vaults, which are less intimidating for patients and improve access for staff. The linear accelerators can provide radiation treatment to about 30 patients a day. • Radiation therapy facilities are also planned for Red Deer, in late 2012, followed by Grande Prairie. Once the five-city Alberta Radiation Therapy Corridor is complete, the number of people having to travel 100 kilometers or more to receive radiation treatment will be reduced from 28% to 8%.

Summary: While improvements have been made reducing wait times for referral to first consult, targets have not been achieved. Focused efforts are underway to further reduce these wait times for the upcoming year.

The target has been achieved for wait time for receiving radiation treatment (ready to treat to first radiation treatment).

Performance Measure	2009/2010	2010/2011	2010/2011 Targets
Access to Cancer Treatment – Radiation Therapy The maximum time that nine out of ten people will wait (in weeks):			
Wait time for radiation therapy – referral to first consult: From referral to the time of their first appointment with a radiation oncologist, by facility.	7.4 weeks	6.0 weeks	4 weeks
Wait time for radiation therapy – Ready to Treat to First Radiation Treatment: From the time of a medical prescription for radiation therapy to the start of radiation therapy, by facility:	5.4 weeks	3.6 weeks	4 weeks

Source: Cancer Care

Note: Jack Ady Cancer Centre (Lethbridge) data is included as of Q3 2010/11.

3.0 TIP - Improving Access, Reducing Wait Times

Priorities for Action: Emergency Department Services

Reduce the length of stay for patients in emergency departments.

Actions	Progress / Results
Establish Medical Assessment Units (MAU) and Clinical Decision Units in the Emergency Departments of 2 major urban centres and evaluate for further implementation provincially.	• Opened 12-bed MAU to the new Emergency Department at Rockyview General Hospital in Calgary in February 2010. • Opened 21-bed MAU at the Royal Alexandra Hospital in Edmonton in October 2010. • Continual monitoring of the MAU's throughput to ensure efficient patient movement from the Emergency Department and through to the patient care units. • Implemented Over Capacity Protocol on December 20, 2010 to manage periods of peak pressures and wait times in the Emergency Departments.
Pilot Emergency Department re-direction projects for Seniors. Appropriately redirect seniors' home from Emergency Departments (EDs).	• Completed Community Health and Pre-Hospital Support (CHAPS) Pilot Project including the development of recommendations and action plan for next steps. • Proposed expansion of the CHAPS program beyond the current pilot program in Calgary Metro and Edmonton Metro for consideration. • Embedded home care resources in Emergency Departments to expedite discharge of seniors and disabled adults to home with appropriate connections to community supports.
Redirection of EMS clients to Urgent Care Centres.	• Increased use of transporting EMS patients to alternate destinations through a pilot project in Strathcona County. • Transports continue to all other Urgent Care Centres in the province. • Work is underway for new Acute Ambulatory Care Centres in LaCrete and Rainbow Lake to receive ambulance transports in the next fiscal year.
Implementation of Treat and Refer protocols to prevent unnecessary Emergency Department admissions and promote referral to the appropriate health and/or social service.	• A project charter is in process of being developed. The Charter outlines specific work that needs to be undertaken regarding the possible options for expanding "assess / treat / refer" practices, including risks and benefits. • Submitted a research proposal to EMS leadership to evaluate the benefits of having an Advanced Paramedic/Nurse Practitioner role available in the pre-hospital environment for patients requiring immediate care but not requiring transport to acute care facility. Discussions initiated with AHW about possible sources of funding. • Developed the Palliative Care Protocol. Implementation to take place in 2011-2012. • Trained EMS to treat in place and connect to community supports to avoid admission to Emergency Department.
Implement system flow initiatives in Hospitals, including the Care Transformation Project at the University of Alberta Hospital.	• The Integrated Plan of Care was initiated within General Internal Medicine at the University of Alberta Hospital on March 29, 2011. • The Integrated Plan of Care project, under the Care Transformation mandate consists of 28 distinct project deliverables which, when taken together reflect a culture transformation that brings a patient-centric approach and embodies team based care. • The noted deliverable of the project is the Integrated Plan of Care. The Integrated Plan of Care consists of the Admission Bundle - a set of clinical documentation that makes up the admission paperwork necessary for patient care and management - and the workflows that support the interprofessional care team approach to the patient journey through the acute care facility.

Summary: Numerous initiatives were implemented over the past year to reduce length of stay in the Emergency Department. A provincial-wide focus has occurred over the past 6 months and improvements are evident in Q4. While achievement of targets did not occur for the last fiscal year, it is well recognized that the length of stay in Emergency Departments is dependent on the functioning of the entire system. We will continue to build on successes of the past year throughout the continuum of care to advance towards the targets.

Emergency Department Length of Stay	2009/2010	2010/2011	2010/2011 Targets
Percent of patients treated and discharged from the Emergency Department within 4 hours:			
Busiest 16 Sites	63%	64%	70%
All Sites	80%	78%	82%
Percent of patients treated and admitted to hospital from the Emergency Department within 8 hours:			
Busiest 16 Sites	38%	41%	45%
All Sites	49%	53%	55%

Source: Calgary and Edmonton Emergency Department Information System Data and AHS Ambulatory Care Reporting System Data

3.0 TIP - Improving Access, Reducing Wait Times

Priorities for Action: Patient Safety

Improve patient safety across the care continuum.

Actions	Progress / Results
Increase standardization and appropriateness for practice by developing clinical pathways through the clinical networks to enhance quality and safety.	• Clinical Networks were established this year with a specific focus: Addiction & Mental Health, Bone & Joint, Cancer Care, Critical Care, Emergency, and Surgery Clinical Network • Clinical Networks comprise of frontline clinicians and healthcare leaders from a variety of disciplines. The Clinical Networks will establish working groups to work on areas identified as priorities including clinical pathways. These working groups will include clinical experts from across the province, operational leaders and patient/family representatives, working to develop improvement strategies and initiatives, generate recommendations and report progress to the core team. • Some clinical pathways completed by March 31, 2011 include: Osteoarthritis and Inflammatory Arthritis, Hip and Knee Arthroplasty, Hip Fracture and Addiction and Mental Health Depression.
Complete full deployment of the Reporting & Learning System application across AHS by March 31, 2011.	• Full deployment of the AHS Reporting and Learning System for patient safety on March 23, 2011. • The new AHS Reporting and Learning System for Patient Safety has replaced up to 12 separate systems currently running in the province, making it the provincial system to enable consistent reporting, evaluation and learning from hazards, close calls and adverse events.
Continue implementation of hand hygiene access points through the Alberta Infrastructure Hand Hygiene grant.	• Province-wide Hand Hygiene Policy and Procedure drafted and undergoing final stakeholder review. • Approval of the AHS Hand Hygiene policy & procedure targeted for May 2011. Concurrent with policy approval an AHS communication and awareness campaign on hand hygiene will be launched. • In collaboration with AHS Communications and utilizing the services of an external communications firm, Calder Bateman developed a creative concept for hand hygiene awareness. Concept is presently being market tested with small groups of healthcare workers and physicians across AHS. • Hand hygiene compliance monitoring pilot initiated in March 2011 which uses iPAD technology and a standardized database iScrub lite. The methodology being piloted includes capacity of the technology and online database to support real time reporting to clinical programs. • Continued use of the Hand Hygiene infrastructure grant to advance access to hand hygiene sinks and alcohol based hand rub across AHS.
Achieve provincial integration of surveillance initiatives for MRSA and C-difficile bacteriums, and blood stream infections.	• Province-wide Infection Prevention and Control (IPC) Surveillance protocol developed and implemented for Antibiotic Resistant Organisms, including MRSA in January 2011. • Developed and implemented a province-wide centralized data system for antibiotic resistant organisms, including MRSA surveillance data in March 2011. This includes all laboratory confirmed MRSA reports arising from routine and targeted screening and clinical samples. Where appropriate legacy data will be incorporated.
Collaborate with AHW on their review of Infection Prevention & Control (IPC) standards.	• Collaboration with AHW on the review and revision of the AHW IPC Single-use Medical Device Standards. Standards are finalized (February 28, 2011) and awaiting Minister of Health approval (anticipated in April 2011). Draft AHS policy on Single-use Medical Devices which will undergo legal and final stakeholder review following release of the revised AHW IPC Single-use Medical Device Standards. • Collaboration with AHW on the review and revision of the AHW IPC Accountability & Reporting Standards throughout the 2010/11 fiscal year.

Summary: Patient Safety remained a high priority over the past year with a variety of initiatives being implemented. In particular, much work has been underway to share best practices across the province and develop standardized provincial approaches. During the next year, focus will be to establish appropriate measures and targets which can be utilized to monitor success of initiatives.

Emergency Department Length of Stay	2010/2011	2010 / 2011 Targets
Never (adverse) Events	Measurement proposed and being evaluated.	Develop Methodology & Baseline
Infection Prevention and Control: **MRSA infection rate:** Hospital acquired methicillin resistant staphylococcus infection rate among patients admitted to: incidence of cases per 100,000 admissions.	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2011/12	Targets will be set following the collection of baseline data and of information on infection prevention and control program activity by AHS.
Surgical site infection rates: Rates of surgical site infections within 30 days of surgery.	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2012/13	Targets will be set following further review of data and a review of national benchmarks.

4.0 TIP - Choice and Quality for Seniors

One in five Albertans will be seniors within the next 20 years. It is important that seniors have access to services and supports to remain healthy and independent as long as possible.

More investment in supportive living options is needed to extend the choices available to seniors. Strategies that allow for a better service match to needs are also important for the overall sustainability of the system. With more options available and better access to caregivers, seniors will be able to live independently as long as possible.

Priorities for Action: Continuing Care

Provide Albertans with options to "age in the right place" by enhancing support services and offering more choice and care options to Albertans in their homes and communities.

Actions	Progress/Results
Expand community and long term care by adding more than 1,100 beds in 2010/2011	• Projected 1,166 contracted Continuing Care Beds / Spaced as of March 31, 2011: ◦ 116 Long Term Care Beds ◦ 1,050 Supportive Living Spaces (60 Supportive Living Level 3,683 Supportive Living Level 4 and 307 Supportive Living Level 4 – Dementia) • 1,370 new Continuing Care spaces identified for 2011-2012 Capacity Plan.
Implement dementia care strategy.	• Dementia Care Strategy completed pending Zone feedback. • Added 307 Supportive Living Level 4 – Dementia spaces by March 31, 2011 • Completed behavioral and symptom management education in Medicine Hat, Manning and Athabasca (Fall 2010). • Trained over 100 registered nurses in dementia and delirium through the Nurses Improving the Care of Hospitalized Elderly (NICHE) program.
Develop quality mechanisms to ensure quality care is delivered.	• Established multi-stakeholder policy, audit, infection prevention and control and reportable incident task groups to develop standardized processes and audit tools in January 2011. • Participated with Alberta Health and Wellness in the first round of provincial consultation process on the Continuing Care Health Service Standards revision. • Conducted review of areas where the Accommodation, Environmental Health, Infection Prevention and Control and Continuing Care Health Service Standards overlap. • Developed standardized business process for AHS Continuing Care Health Service audits that will be applicable in all programs (home care, supportive living and long term care). The process includes the steps in the audit process, definitions, timelines, tools, communication and follows up processes. Standardized audit tools include: letters for each audit component, action plan template; self assessment tool (initial work focusing on Standard 1.7 Infection Prevention and Control); and interview process. • Developed and implemented AHS standardized process for Reportable Incidents. • Facilitated coordination of AHS zone audit visits with Environmental Health inspections, AS&CS inspections and AHW compliance audits. • Developed AHS Seniors Health policy and procedure suite for safe water temperature as it relates to client bathing.
Ensure standardized assessment standards are utilized.	• Completed implementation of Resident Assessment Instrument (RAI), a computerized tool which tracks and improves seniors care.

Summary: The number of clients in hospital waiting continuing care placement dropped in all five zones of the Province. The North Zone (11% improvement) and the South Zone (29% improvement) showed the least improvement, while all other zones registered improvements greater than 40%. The number of clients waiting in the community for Continuing Care Living Options has increased slightly since Q1. This is due in part to the Overcapacity Protocols which increases the priority for placing clients from acute care compared to community. Progress is expected to be shown on community waitlists as the number of net new continuing care spaces continues to increase.

Emergency Department Length of Stay	March 31, 2009	March 31, 2010	March 31, 2011	2010/2011 Targets
Number of People Waiting Continuing Care Placement (snapshot)				
Number of persons **waiting in acute/subacute** hospital bed for continuing care placement	656	707	471	400
Number of persons **waiting in community (at home)** for continuing care placement	1,065	1,039	1,115	975

Source: AHS "Snapshots" of the Wait List at the end of the month

4.0 TIP - Choice and Quality for Seniors

Priorities for Action: Home Care

Provide Albertans with options to **"age in the right place"** by enhancing support services and offering more choice and care options to Albertans in their homes and communities.

Actions	Progress/Results
Expand availability of home care services.	• Work was completed to increase access to home care services through the Self Managed Care (SMC) funding option in order to increase independence and flexibility for clients to choose their own caregivers. The increased availability of SMC option through grant funding has provided clients timely access to home care services. • "Assess, Treat and Refer" protocols have been developed to identity older, at risk, individuals who may need screening for falls, home care and other services. • Implemented programs in Emergency Department to support seniors to return home with added home care support have avoided unnecessary acute hospital stay in the pilot sites which include Rockyview General Hospital in Calgary, Misericordia Community Hospital in Edmonton, Sturgeon Community Hospital in St. Albert and Red Deer Regional Hospital.
Implement consistent homecare service package guidelines.	• A baseline analysis has been completed to assist in identifying gaps and priorities in implementing the Coordinated Access to Publicly Funded Continuing Health Services Directional and Operational Policy. An interview process was used with the Zones to collect and validate data. This baseline data was presented to Zone Seniors Health Executive Directors and Directors on June 1, 2010. The following priorities were agreed upon: ▫ Implementation of case management in continuing care, ▫ Enhance home care staffing for intake, screening and assessment 7 days/week and 24/7 RN on call for Supportive Living, ▫ Implement tools for standardized intake and assessment (i.e. Resident Assessment Instrument (RAI) Contact Assessment, non-RAI assessments), and ▫ Implement home care and supportive living directional and operational policies including: self-managed care, extraordinary funding policy, hardship policy, service guidelines.
Implement Falls Prevention program.	Completed implementation of fall prevention program for specific service areas in which they are to be used. • Acute Care suggested use of the Schmid Fall Risk Assessment toll for screening to identify whether or not a patient is at risk. • Continuing Care suggested use of the Fall Risk Tool for Continuing Care is recommended. • Community based clients a clinician should perform two part screening processes that are based on best practices outlined in the American & Britain geriatrics Society publications. • Assessment of the clients gait, balance and strength by conducting a Timed up and Go Test or the Get up and Go Instructions.
Enhance Caregiver Support and Respite Services.	Work ongoing to increase and enhance education, care, respite, and support services provided to family caregivers in 2011/2012 including: • Provide training of caregiver risk screen / tool. • Development of comprehensive account of caregiver support and respite service options. • Review and promote utilization of current caregiver education programs and support services, designed to address caregiver's needs, such as those offered by Alberta Caregiver Association and Alberta Caregiver College.
Enhance options for palliative care to better support the end of life needs of seniors.	• Joint policy steering committee struck with AHW and AHS. The steering committee objectives are to identify core services for end of life care in Alberta, as well as develop directional policies. • Added 20 palliative beds at the Peter Lougheed Centre in November 2011. • Developing website for provincial hospice / palliative care information, tools and resource directory of providers specializing in palliative care. • Educated over 500 health care providers in Learning Essential Approaches to Palliative Care (LEAP).

Summary: Home care is recognized as a critical component of the health system to enable people to remain in the community and close to home. Over the past year, much effort has been focused on strengthening the foundation of the Home Care Program, so that continued expansion of services can occur in the most efficient, effective and safety manner. During the next year, continued expansion will occur to shift more resources from to the community. In addition, work will be undertaken to establish appropriate measures and targets which can be utilized to monitor success of home care initiatives.

5.0 TIP – Enabling Our People/TIP – Enabling One Health System

The performance of our healthcare system is directly related to the people who provide care and services to the citizens, families and communities we serve. Alberta Health Services is committed to enabling our staff and physicians to provide high quality and safe care by providing the appropriate supports, such as; education, an attractive and safe work environment and the required tools. To move to higher levels of performance, a shared culture will be developed based on the Alberta Health Services' values of Respect, Accountability, Transparency and Engagement.

Alberta Health Services must engage all staff and physicians if we are to realize our Vision and develop a patient centered culture. We will only be as good as we can when we have meaningful engagement. Change management support will guide health providers to be truly focused on the needs and goals of patients and their families. In addition, Alberta Health Services has a responsibility to prepare our people to meet the future needs of an evolving health system and an increasingly sophisticated and knowledgeable public.

Alberta Health Services is the result of the largest merger in Canadian history. AHS is committed to developing administrative support systems and procedures that enable staff and physicians to provide excellent healthcare services to patients, families and communities. The consolidation of a large number of former healthcare entities is a significant undertaking that requires proper planning and determined execution. The delivery of high quality, safe healthcare services depends on efficient and effective supports.

Priorities for Action: Healthy Workforce

Efficiently utilize health professionals within care models that match workforce supply to demand, promote team based delivery of services, and allow for better scope of practice application.

Actions	Progress/Results
Complete Staff and Physician Compensation/ Benefits/Rewards and Recognition Program.	• Out of Scope Flexible Benefits Program implemented July 1, 2010. Approximately. 8,000 Out of Scope employees successfully enrolled. • Implemented AHS medical leadership Compensation Structure and Grid. • Established a Provincial Working Group for the Just and Trusting Culture initiative with a mandate to develop a standard approach and strategy to build the necessary foundation for a quality and safety culture in the organization. • Established AHS Learning and Professional Development Fund to provide accessible funding to AHS employees. • Implemented an informal Employee Appreciation procedure and related funding. • Rolled out of the Management and Exempt Career Framework. • Acquired the Request for Proposal for the conclusion of the legacy Long Service Awards programs. • Many recruitment strategy components are underway with engagement from an employee working group.
Develop a staff and physician learning and development strategy.	• Completed literature review of strategies to support new nurses in their transition into the workplace has been. Information relevant to new graduates is available online. Development of specialty specific orientations is ongoing.
Implement Care Transformation project at University of Alberta (UAH).	• Implemented the Care Transformation project on the general internal medicine units. • The Integrated Plan of Care (IPoC) is the fundamental synthesis of health human resources (our people), current evidence and standards (clinical decision support), optimized processes (clinical, operational, support) and accessibility (ideal care space) in support of patient and family centered care. • The IPoC framework is driving the whole care process, which is now expressed and captured in a fundamentally different way. Instead of individuals creating parallel care process, we are moving towards one team, one plan linking with and transitioning to other care teams along the care continuum.
Complete Staff and Physician Workforce Plan and Recruitment Strategy. Establish a framework to facilitate effective participation of physicians and physician leaders in AHS accreditation activities.	• Completed the Clinical Workforce Strategic Plan. • Implemented preliminary workforce data projections for the next eight quarters by Zone and occupation and for regular replacement as well as for each health plan priority. Identified pressing needs to increase supply of HCAs and Registered Nurses and to initiate retention, productivity and utilization strategies. • A recommended approach has been prepared and is being reviewed for executive committee approval for the "Transitional Grad Nurse Program".

5.0 TIP – Enabling Our People/TIP – Enabling One Health System

Priorities for Action: Healthy Workforce

Efficiently utilize health professionals within care models that match workforce supply to demand, promote team based delivery of services, and allow for better scope of practice application.

Actions	Progress/Results
	• Developing a targeted recruitment initiative to attract and retain current new grads, and developing strategies to attract future classes continues. Discussions have commenced with HSAA regarding incentives to attract people to specific professions and geographic areas. • Work is continuing with regulatory colleges and the University of Calgary to develop a resource tool kit for clinical managers and educators to support the successful transition of the new grad. • Completed the Research to Action I Project final report and accompanying video. Presentations have been made in each zone. The report shows positive outcomes for all retention and recruitment initiatives including transitional grad nurse, week end worker and benefit eligible casual employees. • The accreditation team presented the AHS plan to the Zone Medical Directors and outlined the expectations for their involvement. The accreditation process is being supported at the Zone level.
Develop an AHS physician communication strategy that includes two way communications.	• Embedded within the Physician Engagement Plan are the details of our communication strategy. This plan was completed in Q1.
Implement workplace health and safety certification and mentoring program.	• Implemented foundational training activities for staff, managers and leaders. Training programs included: "It's Your Move" safe client handling training; WHS Management System E-training; AHS Hazard Identification and Control (HIAC) process; Corrective Action, Inspections and Asbestos Awareness. • Implemented the AHS Workplace Health and Safety Stakeholder Engagement framework. • Established the Internal Responsibility System framework. • Implemented the Workplace Health and Safety Provincial Application (feasibility stage).
Implement a workplace health and safety management system including the development of policies, processes and procedures.	• Established Workplace Health & Safety Management System (WHSMS) processes and Safe Work Practices which included the Incident Management Process, Corrective Action Process, Workplace Health & Safety (WHS) General and Focused Inspection Process, Confined Space Code of Practice and Office Ergonomics program (Phase 1). • Implemented an evaluation of the 2010 Workplace Health and Safety Improvement Plans with senior leaders to strengthen and focus the process and metrics for 2011-2012.
Establish engagement and communication plan for workplace health and safety.	• Established Engagement and Communication Program.

Summary: This area was a key area of focus in 2010/2011 and will continue to be emphasized in the upcoming year. The ratio of full-time equivalent to headcount is improving which is important to long-range sustainability and efficiency. Continued work is required on ensuring we have the right workforce to meet the needs of our health system, and that our disabling injury rate is reduced.

Performance Measure	2009/2010	2010/2011	2010/2011 Targets
Health Workforce Plan: Ratio of full-time equivalent (FTE) to headcount. This measure supports workforce efficiencies and indicates better ability to effectively manage scheduling and productivity challenges. FTE count does not include casual employees or wholly owned subsidiary employees.	1.57	1.57	1.63
Percent of Alberta university/college Registered Nurse graduates hired by Alberta Health Services.	Data not previously collected	Total = 87% Non Casual = 41%	70%
Disabling injury rate (staff injury rate).	2.83 (2009)	3.19 (2010)	2.41

Source: Alberta Health Services Human Resources

5.0 TIP – Enabling Our People/TIP – Enabling One Health System

Priorities for Action: Engagement

Enhance staff and physician satisfaction.

Actions	Progress/Results
Develop and implement strategy to improve workforce/physician engagement based upon feedback received.	• The comprehensive Workforce and Physician /Practitioner Engagement Plan was finalized and presented to the Chief Executive Officer in Q1. Representatives of the Chief Medical Officer Office joined the Alberta Clinician Council and the Engagement Working Group to facilitate the integrated approach to physicians with the staff and clinicians of AHS. • A Workforce Engagement Steering Committee met in June 2010. • Executives have dedicated time to meet with groups of employees to discuss the results of the Engagement survey and to solicit ideas for improvement. • An external company has conducted focus group sessions and identified opportunities for improvement. A report was provided to Executive in June 2010. • Senior Vice Presidents and Vice Presidents have developed department specific action plans by June 30, 2010. • An AHS Workforce Engagement Plan was developed by the end of September 2010. • 2010/2011 Performance Agreements include an employee engagement initiative.
Implement initiatives that foster a just and trusting culture; enhance experience as well as attract and retain top quality staff and physicians.	• Just and Trusting Culture (JTC) initiative was launched in February 2010 with the goal of identifying a consistent, standard approach and strategy to build the necessary foundation for a quality and safety culture in the organization. • In 2010, AHS conducted two critical staff / physician census (Workplace Health Safety Culture Survey conducted January / February 2010 and Patient Safety Culture Survey conducted May 2010). Specifically, the Patient Safety Culture Survey measures staff perceptions of safety, what happens after an event and individual actions. • A Working Group was established in December 2010. Principles of Just and Trusting Culture and draft policy have been developed. • The JTC initiative is rooted in AHS values of Respect, Accountability, Transparency and Engagement and intends on linking to other AHS initiatives in order to develop an enterprise-wide culture where staff and clinicians feel safe to identify and report on issues related to quality of care and patient safety.

Summary: The initial survey of staff and physician engagement occurred in February 2010. Over the past fiscal year, many initiatives have been implemented to improve engagement; however the impact of these initiatives is not yet known. The next survey is scheduled for February 2012.

Performance Measure	2010/2011	2010/2011 Targets
Staff and Physician Engagement: Overall engagement score: per cent favourable: Employees/Physicians & Volunteers		
Staff	35%	43%
Physician	26%	43%
Volunteer	35%	79%

Source: 2010 Employee Survey

5.0 TIP – Enabling Our People/TIP – Enabling One Health System

Priorities for Action: Information Technology and Information Management

Improve the quality and cost-effectiveness in health care service delivery through electronic management and use of medical information.

Put in place the consolidated systems and capabilities to create a sustainable operating environment for AHS. Systems range from HR/Payroll and Finance to Clinical Information and Reference systems.

Actions	Progress/Results
Review and update IT Strategy, with input from stakeholders, to reflect updates to AHS directions.	• Through work with stakeholders within AHS as well as AHW and in conjunction with the 5 Year Health Action Plan, the Information Technology department created a 'Five Year IT Plan' which was approved in December 2010. This plan is the primary AHS input into a joint initiative with AHW, AMA, CPSA and other health system stakeholders. The plan is being finalized and printed for distribution in May 2011.
Complete IT Roadmaps to facilitate the identification of IT initiatives and priorities.	• Alberta's 5 Year Health System IT Plan contains a broad view of the IT Roadmaps for the administrative and clinical areas of AHS as well as IT infrastructure and foundation requirements.
Implement and consolidate major business systems in the area of information technology for business and clinical areas.	• System consolidation activities in 2010/2011 were highlighted with the completion of the project to implement a single financial system – Procure To Pay (P2P). Another significant completion of a single provincial system is Provincial Patient Safety Reporting. • Significant system consolidation initiatives also completed in Diagnostic Imaging, Lab, Environmental Health as well as number of foundational initiatives within Information Technology such as Active Directory, Network Inpatient Addressing and security incident management. These consolidation activities simplify the information technology environment for the departments through reducing the number of systems in use. • Consolidation initiatives in HR (e-People), Health Information Management, Pharmacy, Public Health and Information Technology made significant progress in 2010/11 towards their objectives and completion.
The Phase 1 IT Security Initiative was the first deliverable in the AHSecure Program. In 2010/2011, the AHSecure Program will continue with several other initiatives, including the first major deployment of Identity and Access Management, secure email deployment, IT risk management framework, and others.	• The AHSecure program delivered on several initiatives in FY 2010/2011: a secure email service to allow communications to external partners or patients; a draft IT controls framework has been developed and will be implemented in 2011/2012; the initial deployment of Identity and Access Management has been developed and will be deployed in conjunction with the HRMS e-People project rollout for fall 2011; hard drive encryption software was replaced for all mobile computers in the Calgary and South Zones; and the security awareness program has been refreshed and redeployed including new policies, confidentiality forms, and a new training video. In addition, several other initiatives have been started that will meet significant milestones in 2011/2012: • Internet gateways will be consolidated from 14 to 2, complete with new hardware and functionality; • Security logging and auditing functionality will be deployed to better detect security threats; • A provincial standard for upgraded and enhanced anti-virus and endpoint protection security software will begin to be deployed across the province; and • Identity and Access management for Alberta Netcare will be deployed by November 2011.

Summary: Numerous IT initiatives continue to be implemented on a provincial-wide basis. Investment in technology is critical to enable a high functioning, safe, efficient health system and this will continue to be coordinated as a major component of one of our Transformational Improvement Programs (TIP).

Performance Measure	2009/2010	2010/2011	2010/2011 Targets
Information Technology and Information Management:			
Alberta Netcare: Number of physician and nurse users who access the Electronic Health Record system across the continuum of care.	10,067 peak quarter	11,816 in Q4 17% increase	+15% increase
Alberta Health Services Information Technology Strategy: Consolidate, Unify, Optimize. Move to common systems for all of AHS needs to provide standardization around common processes, tools and information.	Email system, networks & IT services consolidated & optimized	Financial systems consolidation process achieved	Complete Phase 1 of HR/Payroll & Financial systems consolidation 24 systems replaced by 2. Pilot Interactive Continuity of Care Record
Alberta Health Services Information Technology Strategy: Reduction in AHS Information Technology operating budget support (cost savings associated with consolidating software service and support contracts).	$200 Million (2009/2010)	Actual savings achieved $10.4 Million	-5% decrease from 2009/2010 Target was $7.2 Million

5.0 TIP – Enabling Our People/TIP – Enabling One Health System

Priorities for Action: Fiscal Efficiencies

Fiscally responsible and good stewardship of resources. Reduce duplication and streamline processes to improve efficiencies.

Actions	Progress/Results
Develop new operating budget process.	• 2011/2012 Budget Process was initiated in October 2010. The budget is integrated with the Health Plan and was presented to the Audit and Finance Committee in January-February 2011.
Implement and consolidate major business systems in the areas of finance, human resources, data management and purchasing.	Work is progressing rapidly on many other projects like the Human Resources Management System, which will make it easier to access payroll and HR information. Other accomplishments include: • The Internal Website, Finance page now has a comprehensive list of contacts and finance forms in use today. It's something that's simple, but very useful. • I-procurement, an online procurement system – allows staff to order items such as tools, hoses, motors – and even toilets – online. Previously a paper requisition had to be filled out and approved by a manager. The online system has cut the time between ordering and receiving items from 40 hours to one hour, a 96% improvement. We are working on putting this system in place across the organization. • Actively working on moving to one single shared technology platform (Oracle R12) which will enable everything from the Consolidation of Item and Supplier Master lists to a province-wide General Ledger – providing a 'single source of truth' for management reporting.
Complete capital projects reconciliation by yearend audit on time.	• Business Advisory Services (BAS) Capital initiated the reconciliation of the Consolidated Cash Investment Trust Fund accounts of legacy regions in 2009 at the request of the Alberta Government. The project gained momentum in the spring of 2010 with the addition of dedicated resources but was hampered by a loss of corporate knowledge and documentation which occurred as a result of the amalgamation of the health regions. The reconciliation took several months and was completed in large part by late November 2010. This information was shared with Alberta Infrastructure and Alberta Health and Wellness following which further review was initiated by Alberta Infrastructure. BAS Capital and Capital Management continue to provide information to support further review of the reconciliation to both Alberta Infrastructure and AHS Auditors.
Procure to Pay (P2P) System Installed.	• Procure to Pay (P2P) Phase 1 went live February 2011. AHS is now in the stabilization period and remediation activities are underway to address known issues.
Install Budgeting and Management Reporting System.	• First phase of the management reporting tool went live in March 2011. • Completed implementation of OFA tool which will be used to manage the 2011-2012 budget. • Request for Proposal to select an implementation partner of the Hyperion Budget system which was posted on March 21, 2011.
Implement and further expand activity based funding methodology.	• Alberta Health Services began implementing Activity-Based Funding (ABF) in Long-Term Care (LTC) April 1, 2010. This work is continuing, with phasing-in to be complete by March 31, 2017. Data is being collected to allow implementation of ABF in bed-based supportive living, possibly as early as April 2012. Approaches to introducing ABF for acute services are being developed, also for potential implementation in April 2012. Overview of ABF Allocations in 2010/11: • AHS increased LTC funding overall by 4% (the average for all operators), consisting of ◦ 2% for all LTC Operators (based upon the rates in effect as at March 31st, 2009). ◦ 2% to start the implementation based on acuity in LTC. This will start to re-distribute funding more equitably, relative to the needs of their clients. • No LTC providers received less than 2% in 2010/2011, and those having the greatest cost pressures received additional increases. • An additional $8 million was allocated to LTC facilities found to be receiving less than the target provincial level of funding.

Summary: The financial summary can be found in the Financial Overview of this document.

Performance Measure	2010/2011	2010/2011 Targets
Adherence to Five-Year Budgeted Government Funding: AHS will operate within the approved 5-year funding agreement with the Government of Alberta, and will not record an accumulated deficit at the conclusion of this period as recorded in the overall Alberta Health Services audited financial statements. Surplus / (Deficit).	The accumulated surplus at March 31, 2011 is $116 million which is within 1.5% of the annual funding agreement ($136 million)	Variance no greater than + or - 1.5% of the annual funding agreement

6.0 Foundational/Organization-wide

There are a number of other actions and measures that relate to the overall development and functioning of Alberta Health Services that will help us advance our goals. Although many of these foundational actions have been described in other sections of this document, there are performance measures designed to help ensure we are improving overall patient satisfaction with services, that we are fulfilling our reporting obligations to the government, that we are engaging our communities and that we are improving the quality of our services through accreditation mechanisms.

Priorities for Action: Fiscal Efficiencies

Deliver a **patient-focused system** that captures patient perspectives on care and services received so as to improve health system quality and responsiveness to patient needs. Increase patient satisfaction with the care and services received.

Actions	Progress/Results
Implement a provincial Feedback and Concerns Tracking System (FACT) by March 31, 2011.	• The Patient Relations Department for Alberta Health Services has fully implemented the Feedback and Concerns tracking system (FACT) as of November 1, 2010. • The database will support a consistent province-wide approach to receiving and tracking patient feedback received by the Patient Relations Department. As of November 1, 2010 Patient Relations is able to provide reports on the number of concerns and commendations that are classified into primary and secondary categories by program and zone level.

Summary: AHS works closely with HQCA (Health Quality Council of Alberta) to monitor Patient satisfaction. Over the past fiscal year, many initiatives have been implemented to improve patient satisfaction; however the impact of these initiatives is not yet known. The next patient surveys are scheduled for 2011 and 2012.

Performance Measure	Baseline	2010/2011	2010/2011 Targets
Satisfaction with health care services received: Percentage of Albertans satisfied or very satisfied with health care services personally received in Alberta within the past year.[1]	62% (2010)	Next HQCA Survey in 2012	65%
Acute Care – Hospital Services: Percentage of patients rating hospital care as 8, 9, or 10 on a scale from 0 to 10, where 10 is the best possible rating.[2]	Data not previously collected	82%	80%
Continuing Care: Long-Term Care Facilities. Overall **family** rating of care at nursing homes, on a scale from 0 to 10. Average score.	8.1 (2008)	Next HQCA Survey in June 2011	TBD
Overall **resident** rating of care at nursing homes, on a scale from 0 to 10. Average score.	8.0 (2008)	No HQCA Survey Planned	TBD
Assisted Living[3] **Home Care**[4]	TBD	Work Ongoing	Planning stage to March 31, 2012
Emergency Department Care – Past Year: Percentage satisfied or very satisfied with their or a close family member's services at an emergency department in past year	58% (2008)	59% (2010)	TBD
Emergency Department Care – Within three weeks of receiving the service: Percentage rating emergency department care as excellent or very good within three weeks of receiving the service.	65%	Next HQCA Survey in Oct. 2011	TBD
Emergency Medical Services (EMS)	TBD	Work Ongoing	Implementation in 2011/2012
Mental Health Services: Percent of Albertans who were satisfied or very satisfied with the mental health services they received.[5]	74% (2008)	78% (2010)	TBD

[1] Source: Health Quality Council of Alberta. Satisfaction and Experience with Health Care Services: A Survey of Albertans 2010.

[2] Source: Alberta Health Services. Provincial Hospital - CAHPS Survey.

[3] A client survey on Assisted Living services is in the planning stage with Alberta Health Services and the Health Quality Council of Alberta.

[4] A client survey on Home Care services is in the planning stage with Alberta Health Services and the Health Quality Council of Alberta.

[5] Source: Health Quality Council of Alberta. Satisfaction with Health Care Services: A Survey of Albertans 2008.

6.0 Foundational/Organization-wide

Priorities for Action: Governance

Alberta Health Services demonstrates good governance.

Actions	Progress/Results
Develop Strategy cycle in conjunction with AHW.	• Approved a strategic planning cycle that supports a whole system approach, and aligns with AHW requirements in September 2010. This allows for the integration of requirements for Capital and Finance planning, and appropriate time allotment for other related planning, development and approval processes.

Priorities for Action: Community Engagement

Effective **community engagement** and public consultation that supports effective planning, delivery and evaluation of health services.

Actions	Progress/Results
Hold Health Advisory Council meetings in 2010/2011.	• Completed the first year of operation. Health Advisory Councils support Alberta Health Services to achieve our strategies by providing advice and feedback from a local perspective on what is working well in the health care system and what areas are most in need of improvement.
Create work plans for all Councils including mechanisms councils will adopt for engaging the communities they represent.	• Developmental initiatives were implemented to represent the geographical area each council serves. A chair was nominated as well as a vice chair for each represented council, producing and annual work plan and acting on strategies they identified to fulfill their mandates. • 2010-2011 Annual reports are being produced to highlight the work accomplished over the year.
Establish website on the Community Engagement which will host useful information for Foundations and Health Trusts.	• Established infrastructure to support council operation during 2010/2011. A webpage for each council was made on the Alberta Health Services website, individual council email addresses, daily communications and background information on emerging news or issues, attendance at Alberta Health Services Board engagement events, two recruitment campaigns to fill vacant positions and a member satisfaction survey.
Disseminate Community Engagement Framework. The methodology of how to engage the community will be available through multiple channels for all staff.	• The coming year will see councils increase the number of community consultations held with Albertans to provide Alberta Health Services with more feedback on the local perspective surrounding health care delivery in communities across the province.

Priorities for Action: Accreditation

AHS undertakes **accreditation** activities in compliance with the Minister's directive on mandatory accreditation.

Actions	Progress/Results
Undertake Accreditation activities.	• An annual report was completed and submitted in March 2011 to Alberta Health and Wellness outlining Alberta Health Services' accreditation activities for the past year.
Participate in Accreditation Canada's accreditation process and work within the provincial standards framework.	• AHS is currently participating in a three year sequential cycle with Accreditation Canada for 2010-2012. The first on-site survey visit occurred October 24-29 2010. • AHS received a certificate of accreditation which is valid from 2010 to 2013. Some conditions were identified during the 2010 survey visit and are being addressed. Teams continue to work on their action plans as part of the continuous quality improvement supported by Accreditation in anticipation of the 2011 and 2012 on-site survey visits.
Participate in the College of Physicians and Surgeons of Alberta Accreditation of diagnostic programs.	• A service agreement has been developed for CPSA to provide accreditation services for Laboratory Services, Diagnostic Imaging Services, Neurophysiology and Pulmonary Function Test Labs for AHS, Covenant and Lamont Healthcare Centre. • There were no assessments completed in 2010.

Financial Statement Analysis

For the year ended March 31, 2011 (in millions of dollars)

Purpose

This Financial Statement Analysis is provided to enable readers to assess Alberta Health Services' (AHS's) results of operations and financial condition for the year ended March 31, 2011 compared to budget and to the preceding year.

This Financial Statement Analysis should be read in conjunction with the audited consolidated financial statements, notes and schedules dated June 10, 2011. The consolidated financial statements are prepared in accordance with Canadian generally accepted accounting principles and reporting requirements of Financial Directives issued by Alberta Health and Wellness (AHW). All amounts are in millions of dollars unless otherwise specified.

Financial Statement Analysis

For the year ended March 31, 2011 (in millions of dollars)

Overview of 2010/2011

The following table summarizes the Consolidated Statement of Operations:

Statement of Operations	Budget 2011	Actual 2011	Variance	Actual 2010	Increase (Decrease)
Revenue	$11,811	$11,832	$21	$10,239	$1,593
Expenses	11,181	10,976	205	10,477	499
Operating surplus (deficit)	$630	$856	$226	$(238)	$1,094
Less: Deficit funding	(527)	(527)	0	(343)	(184)
Operating surplus (deficit) excluding deficit funding	$103	$329	$226	$(581)	$910

AHS commenced operations on April 1, 2009 with an opening accumulated deficit of $343 from the former health entities. In February 2010 the five-year funding commitment for health was announced including funding the accumulated deficit of AHS after the first year of operations in two phases: $343 in 2009-2010 and $527 in 2010-2011.

The AHS operating surplus excluding deficit funding for the year ended March 31, 2011 is $329 compared to a budget of $103. The $226 positive variance is primarily due to lower than budgeted expenses resulting from the timing of recruitment of positions for the implementation of new initiatives and filling of vacancies, lower utilities expenses, and higher patient fees and charges.

The 2010-2011 operating surplus impacted accumulated surplus (deficit) and was utilized as follows:

Accumulated deficit, beginning of Year	$(527)
Current Year operating surplus	856
Accumulated surplus before transfers and internal restrictions	$ 329
• Used for internally funded capital assets	$(146)
• Internal restrictions to assist funding of South Health Campus in Calgary and to establish a parking infrastructure reserve for future maintenance, upgrades and construction	$ (67)
Accumulated surplus, end of Year	$ 116

The resulting accumulated surplus for the year ended March 31, 2011 is $116. AHS annual expenditures of $10,976 equate to approximately $30 per day, hence the accumulated surplus represents approximately 3.8 days of expenses.

In order to facilitate management of the organization's cash flows and ongoing requirements, AHS is continuing discussions with AHW on its operating and capital funding arrangements and is continually assessing working capital requirements, expenditure plans and borrowing options. The working capital surplus as at March 31, 2011 amounted to $12 compared to a working capital deficiency of $515 as at March 31, 2010. The improvement in working capital is primarily due to higher levels of cash and cash equivalents eliminating the accumulated deficit. In addition, AHS presently has access to an unutilized $220 line of credit.

Statement of Operations

Revenue

Revenue	Budget 2011	Actual 2011	Variance	Actual 2010	Increase (Decrease)
Alberta Health & Wellness contributions	$10,300	$10,312	$12	$8,852	$1,460
Other government contributions	98	101	3	103	(2)
Fees and charges	612	622	10	578	44
Ancillary operations	112	112	0	120	(8)
Donations	30	29	(1)	20	9
Investment and other income	289	292	3	261	31
Amortized external capital contributions	370	364	(6)	305	59
Total revenue	$11,811	$11,832	$21	$10,239	$1,593

Total 2011 revenues increased by $1,593 or 15.6% from 2010 and were higher than budgeted amounts by $21. This increase was primarily due to increased contributions received and recognized from AHW during 2011. $10,312 of revenues were sourced from AHW, representing 87.2% of total revenues in 2011, as compared to $8,852 or 86.5% in 2010. Other sources of revenues listed totalled $1,520 in 2011 or 12.8%, compared to $1,387 or 13.5% in 2010.

Significant variances are explained as follows:

- **Alberta Health & Wellness (AHW)** contributions are either unrestricted or restricted in nature. Unrestricted funding is the main source of operating funding to provide health care services to the population of Alberta and is approximately 87.2% of total revenue for AHS. Restricted funding is revenue that can only be used for specific projects and is recognized when the related expenses are incurred.

  AHW contributions resulted in a positive variance of $12 as compared to budgeted levels.

  AHW contributions increased by $1,460 in 2011 compared to 2010 due to the increase in base operating funding and funding received for net accumulated deficit elimination; offset by the impact of delayed implementation of projects funded by restricted contributions.

- **Other government contributions** is ongoing and one-time contributions for operating purposes from federal, provincial (other than AHW) and municipal governments.

  The decrease in other government contributions of $2 as compared to the prior year is primarily due to the reclassification of revenue recognized for student health initiatives funded by the various school boards from other government contributions to other operating grants.

- **Fees and charges** consist of patient revenue for health services at rates set by the Minister of Health and Wellness and collected by AHS and contracted long-term care providers from individuals, Workers Compensation Board (WCB), federal and provincial governments, and other responsible parties such as Alberta Blue Cross and insurance companies.

  The $10 positive variance in fees and charges is mainly due to the increase in revenue from insured, uninsured, and out-of-province residents partially offset by decrease in other payment sources.

  The increase of $44 as compared to the prior year is mainly attributable to the increase in revenue from long-term care patients and out-of-province residents.

Statement of Operations

- **Ancillary operations** include parking, non-patient food services and the sale of goods and services.

  The decrease of $8 as compared to the prior year is primarily due to the decrease in rental revenue and sales of goods and services; offset by an increase in parking revenue.

- **Donations** include contributions from foundations and voluntary donations for non-capital purposes that are restricted and unrestricted. Capital contributions from foundations are reported on the Consolidated Statement of Cash Flows.

  The increase of $9 as compared to the prior year is mainly due to the increase in donations received for cancer research.

- **Investment and other income** is comprised of interest income, dividends, net realized gains and losses on disposal of investment, recoveries and revenue from drug companies, medical supply companies, and universities, and other nongovernment grants.

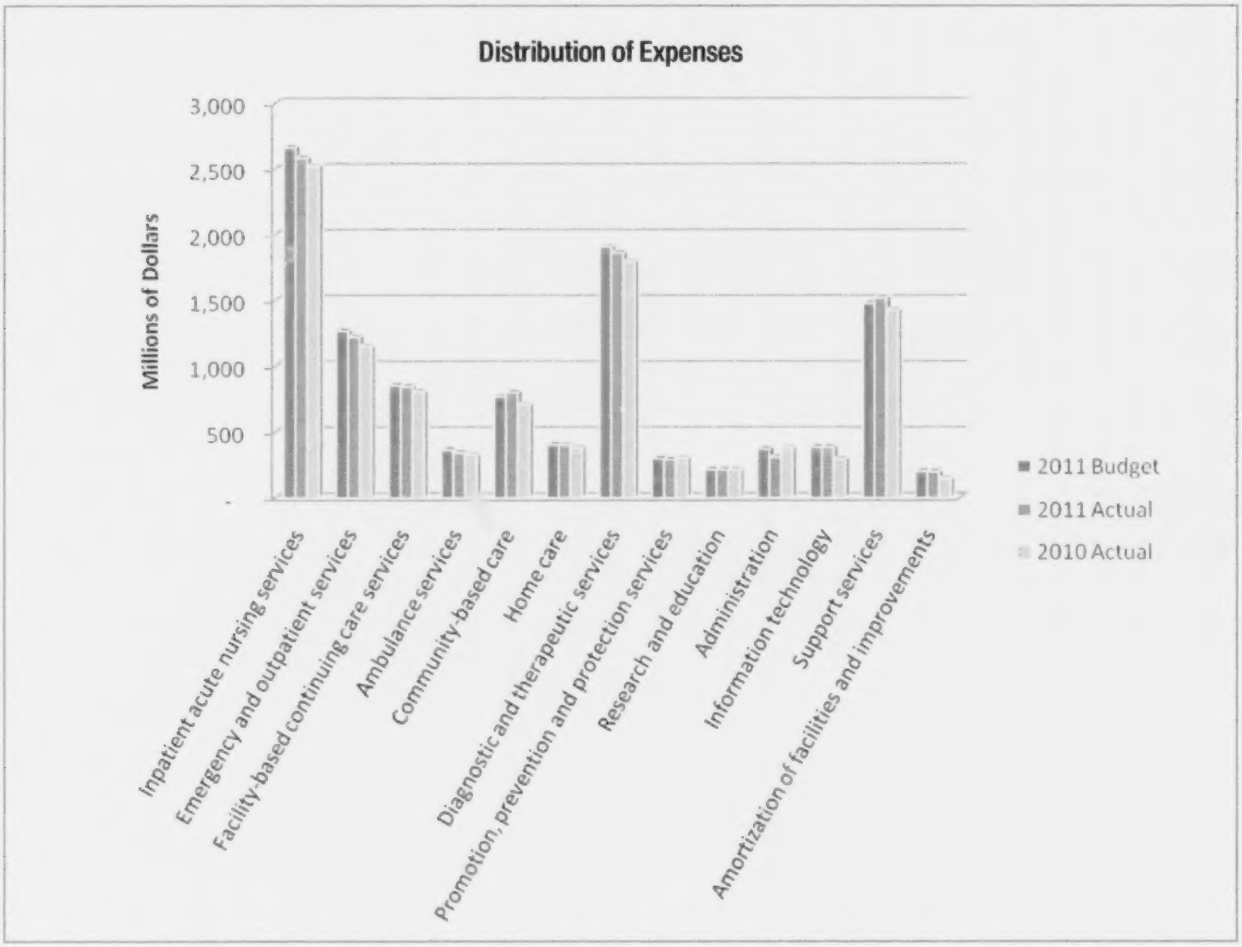
  The increase of $31 from the prior year is due to the increase in interest income, one-time capital gains on investment, and revenue related to the consolidation of the Provincial Health Authorities of Alberta and Liability Property Insurance Plan with AHS.

- **Amortized external capital contributions** are the restricted revenue recognized from external agencies for capital assets that are amortized during the period.

  The increase of $59 as compared to the prior year is mainly attributed to the capitalization of substantially complete infrastructure and information systems projects.

Statement of Operations

Expenses – By Program



Total expenses in 2011 increased by 4.8% from 2010 and were lower than budgeted amounts by 1.8%. This increase in expenses was primarily due to labor and contract inflation, increased usage of overtime, increased volumes and expansion of services. AHS' distribution of expenses has remained consistent with the previous year, with inpatient acute nursing services and diagnostic and therapeutic expenses making up over 40% of total expenses. The largest increases as compared to the prior year were seen in facility-based continuing care, information technology, community-based care, and support services.

Significant variances are explained as follows:

- **Inpatient acute nursing services** is comprised predominantly of nursing units, including medical, surgical, intensive care, obstetrics, pediatrics and mental health. This category also includes operating and recovery rooms.

  Inpatient acute nursing services amounted to $2,584 compared to a budget of $2,664 resulting in a positive variance of $80 or 3.0% mainly due to timing of recruitment for additional front line positions.

  There is an increase of $61 over prior year mainly due to labor inflation, added hospital beds (including transition, medical assessment, and hospice beds), and increased surgical activity.

Statement of Operations

- **Emergency and outpatient services** are comprised primarily of emergency, day/night care, clinics, day surgery, and contracted surgical services.

  Emergency and outpatient services amounted to $1,221 compared to a budget of $1,266 resulting in a positive variance of $45 or 3.6% mainly due to timing of recruitment of front line staff and physicians resulting in delayed implementation of new program initiatives.

  There is an increase of $70 over prior year due to increased costs related to inflation, growth, and new program initiatives to reduce emergency department wait times. The growth consists of increased program and clinic volumes in Midwifery, Gastroenterology, Catheterization Labs, Renal, and Cardiac Specialties including Implantable Cardiac Devices.

- **Facility-based continuing care services** are comprised of long-term care including chronic and psychiatric care operated by AHS and contracted providers.

  Facility-based continuing care services amounted to $845 compared to a budget of $853 resulting in a positive variance of $8 or 0.9%.

  There is an increase of $38 over the prior year due to increases related to contracted rate inflation, and incremental annual impacts of 2009/10 and new 2010/11 care spaces opened as part of the Continuing Care Capacity Plan.

- **Ambulance services** are comprised of EMS ambulance, patient transport, and EMS central dispatch.

  Ambulance services amounted to $343 compared to a budget of $364 resulting in a positive budget variance of $21 or 5.8% mainly due to the delayed transitioning of Air Ambulance and First Nation Ambulance services to AHS, staff vacancies, and reduced spending on equipment, travel, and communications as a result of consolidating EMS operations across the province.

  There is an increase of $17 over prior year mainly due to settled and anticipated contract inflationary increases and part year costs of transitioning Air and First Nation Ambulance services. These increases are partially offset by reductions in spending as mentioned above.

- **Community-based care** is comprised primarily of supportive living, and palliative and hospice care. This category also consists of community programs; primary care networks (PCNs), urgent care centres, and community mental health.

  Community-based care amounted to $800 compared to a budget of $768 resulting in a negative variance of $32 or 4.2% mainly due to drug expenses offset by grant revenue.

  There is an increase of $94 over prior year mainly due to opening of new supportive living spaces in 2010/11 and contract inflation increases.

- **Home care** is comprised of home nursing and support.

  Home care amounted to $402 compared to a budget of $404 resulting in a positive variance of $2 or 0.5%.

  There is an increase of $21 over prior year mainly due to an increased focus on Home Care nursing through Emergency Department Wait Times Initiatives and Over Capacity Protocols, contract rate inflation, and filling vacant positions from 2009/10.

- **Diagnostic and therapeutic services** is comprised primarily of clinical lab (both in the community and acute), diagnostic imaging, pharmacy, acute and therapeutic services such as physiotherapy, occupational therapy, respiratory therapy and speech language pathology.

Statement of Operations

Diagnostic and therapeutic services amounted to $1,862 compared to a budget of $1,909 resulting in a positive variance of $47 or 2.5% mainly due to staffing vacancies and timing of recruitment of front line staff, delays in implementation of new program initiatives such as the Mazankowski Alberta Heart Institute MRI, and support for Medical Assessment Unit / Medical Observation Unit openings.

There is an increase of $65 over prior year mainly attributable to contracted rate increases, increased MRI exams, and filling of some 2009/10 vacant positions.

- **Promotion, prevention and protection services** are comprised primarily of health promotion, disease and injury prevention, health protection, and emergency preparedness.

  Promotion, prevention and protection services amounted to $289 compared to a budget of $296 resulting in a positive variance of $7 or 2.4%.

  There is a decrease of $14 from prior year mainly due to the 2009/10 emergency preparedness activity related to H1N1. This is offset by increased costs related to wage and contract rate inflation and filling of staff vacancies.

- **Research and education** pertains to formally organized health research and graduate medical education, primarily funded by donations and third party contributions.

  Research and Education amounted to $214 compared to a budget of $215 resulting in a positive variance of less than $1 or 0.5%.

- **Administration** is comprised of human resources, finance and general administration.

  Administration amounted to $307 compared to a budget of $375 resulting in a positive variance of $68 or 18.1% due to vacancy management initiatives and savings targets achieved, decreased discretionary spending in the areas of consulting services, travel, and education/sundry expenditures, and reduced specialized recruitment and retention programs.

  There is a decrease of $74 from the prior year mainly due to the 2009/10 impact of transferring employer groups from PSPP to LAPP, one time HRMS contract termination costs in 2009/10, reduced severance costs, and other planned savings and reductions in discretionary spending.

- **Information technology** is comprised of infrastructure and systems support, device and print services, data processing, system development and software.

  Information technology amounted to $388 compared to a budget of $385 resulting in a negative variance of $3 or 0.8%.

  There is an increase of $94 over prior year attributable to first year maintenance costs, one time software licenses, and centralization of services including end user devices. The increase also includes contract and salary wage rate increases, technical support contract increases, and other capital project completions transitioning to operations. Partially offset by cost savings associated with consolidating software service and support contracts.

- **Support services** is comprised of building maintenance operations (including utilities), materials management (including purchasing, central warehousing, distribution and sterilization), housekeeping, laundry and linen services, patient registration, health records and food services.

  Support services amounted to $1,522 compared to a budget of $1,479 resulting in a negative variance of $43 or 2.9% mainly due to a one time capital grant to Covenant Health, increases in rental and lease operating costs and rates, and centralization of insurance. These costs are partly offset by staffing vacancies, lower than expected utility costs, planned savings, and reduced renovations charged to operations.

Statement of Operations

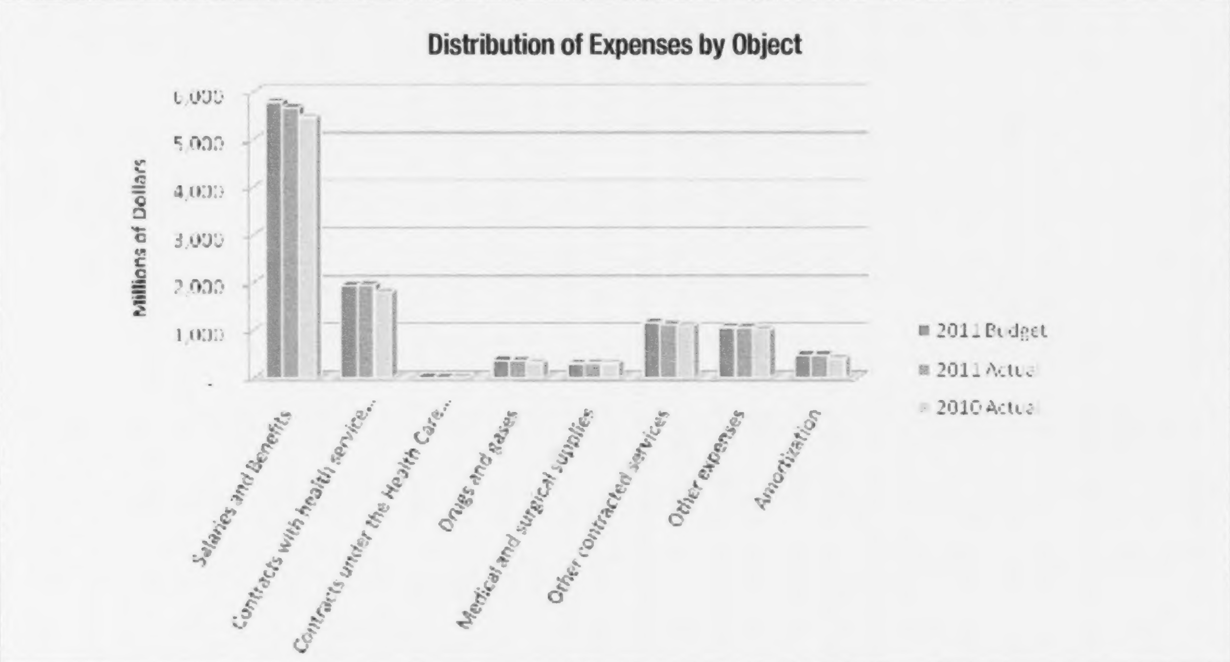
There is an increase of $94 over the prior year mainly due to a one time capital grant to Covenant Health, opening of new physical space, increased lease costs, contracted rate increases for rentals and leases, and salary rate increases for staff.

- **Amortization of facilities and improvements** is comprised of amortization of buildings, building service equipment and land improvements capitalized by AHS (exclusive of the portion of amortization charged to ancillary operations). Amortization of equipment is not disclosed separately on the statement of operations, but is instead included in each of the other expense classifications above.

  Amortization of facilities and improvements amounted to $198 compared to a budget of $202 resulting in a positive variance of $4 or 2.0%.

  There is an increase of $51 over the prior year mainly due to the completion of several capital projects adding new physical capacity such as McCaig Tower, Peter Lougheed Centre, Mazankowski Alberta Heart Institute, Robbins Pavilion – Ortho Surgery Centre, Rockyview General Hospital, and Richmond Road Diagnostic and Treatment Centre.

Expenses – By Object



The distribution of expenses by object has remained consistent with the prior year, with salaries and benefits making up more than half of total expenses.

Significant variances are explained as follows:

- **Salaries and benefits** comprises worked hours, non-worked (benefit) hours which includes vacation and sick leave, base salary which includes pensionable base pay, other cash benefits, which includes overtime, employee benefit contributions made on behalf of employees and severance.

  Salaries and benefits amounted to $5,667 compared to a budget of $5,804 resulting in a positive variance of $137 or 2.3% mainly relating to vacant positions and timing of recruitment.

  There is an increase of $184 over prior year mainly due to inflation and increased overtime expense.

Statement of Operations

- **Contracts with health service providers** include voluntary and private health service providers with whom AHS contracts for health services.

  Contracts with health service providers amounted to $1,958 compared to a budget of $1,950 resulting in a negative variance of $8 or 0.4% mainly relating to a one time capital grant provided to Covenant Health. This variance is partially offset by a positive variance to budget as a result of delayed spending on air ambulance and First Nations ambulance transition to AHS.

  There is an increase of $159 over prior year due to inflation, increase in continuing care beds, increased home care activity, and one time capital grant payment to Covenant Health.

- **Contracts under the Health Care Protection Act** relates to contracts with surgical facilities pursuant to the Health Care Protection Act which is about ensuring more efficient delivery of publically funded services by allowing contracting out to profit-orientated surgical facilities.

  Contracts under the Health Care Protection Act amounted to $19 compared to a budget of $21 resulting in positive variance of $2 or 9.5% due to fewer procedures than anticipated.

  There is a decrease of $5 over prior year.

- **Drugs and gases** expenses include all drugs used by AHS, including medicines, certain chemicals, anesthetic gas, oxygen and other medical gases used for patient treatment. Drugs used for other than patient treatment are not considered to be part of this category, but rather included in other expenses.

  Drugs and gases amounted to $361 compared to a budget of $384 resulting in a positive variance of $23 or 6.0% the majority of which is offset by revenues funded through a restricted grant for specialty high cost drugs.

  There is an increase of $29 over the prior year mainly due to the increase in drug usage related to cancer care.

- **Medical and surgical supplies** are those used throughout the province, including prostheses, instruments used in surgical procedures and in treating and examining patients, sutures and other supplies.

  Medical and surgical supplies amounted to $330 compared to a budget of $314 resulting in a negative variance of $16 or 5.1% mainly due to inventory adjustments to Calgary operating rooms as a result of standardizing accounting practice across all areas of the province and increases in surgical and other clinical activities.

  There is an increase of $10 over the prior year mainly due to inventory adjustments and increased surgical activity.

- **Other contracted services** are payments to those under contract that are not considered to be employees. This category includes fee-for-service payments to physicians, referred-out services and purchased services.

  Other contracted services amounted to $1,112 compared to a budget of $1,165 resulting in a positive variance of $53 or 4.5% mainly due to the termination of an outsourced payroll contract repatriated as in-house services now captured under different expense categories and recruitment issues with physician appointments.

  There is an increase of $10 from prior year due to increases in technical support contracts.

- **Other expenses** relate to those not classified elsewhere.

  Other expenses amount to $1,056 compared to a budget of $1,065 resulting in a positive variance of $9 or 0.8% mainly due to market utility rates being lower than budgeted partly resulting from the implementation of hedging activities.

  There is an increase $52 over the prior year mainly due to expenditures on software licenses and information technology equipment such as end user devices including computers.

- **Amortization expenses** relates to the periodic charges to expense representing the estimated portion of the cost of the respective physical asset that expired through use and age during the period.

  Amortization expenses amounted to $471 compared to a budget of $479 resulting in a positive variance of $8 or 1.7%.

  There is an increase of $59 over the prior year relating to the completion of several capital projects adding new physical capacity such as McCaig Tower, Peter Lougheed Centre, Mazankowski Alberta Heart Institute, Robbins Pavilion – Ortho Surgery Centre, Rockyview General Hospital, and Richmond Road Diagnostic and Treatment Centre.

Statement of Financial Position

The following table summarizes the Consolidated Statement of Financial Position:

Statement of Financial Position	Actual 2011	Actual 2010	Increase (Decrease)	% Increase (Decrease)
Current assets	$2,284	$1,386	$898	64.8%
Non-current assets	7,533	7,389	144	1.9%
Total assets	$9,817	$8,775	$1,042	11.9%
Current liabilities	$2,272	$1,901	$371	19.5%
Non-current liabilities	6,585	6,746	(161)	(2.4)%
Net assets	950	118	832	705.1%
Endowments	10	10	0	0.0%
Total liabilities and net assets	$9,817	$8,775	$1,042	11.9%

Current assets are primarily made up of cash, cash equivalents and accounts receivable. Current assets increased by $898 in 2011 mainly as a result of an increase in cash and cash equivalents of $744 and contributions receivable from Alberta Health and Wellness of $121. The increase in cash was the result of higher revenues, including one-time deficit funding of $527 which led to an operating surplus of revenues over expenses of $856. The increase in contributions receivable from AHW at year-end was due to the timing of AHW funding approval.

Non-current assets are primarily made up of capital assets and the non-current portion of the cash and investments. Non-current assets as a whole remained flat year over year increasing by only 1.9% or $144. In 2011, there was an increase in capital assets of $556 partially offset by a decrease of $400 in non-current cash and investments. Since most capital projects are externally funded, capital expenditures increase capital assets and while decreasing deferred capital contributions which is part of non-current liabilities.

Current liabilities are primarily made up of accounts payable, accrued liabilities, deferred contributions and accrued vacation pay. Current liabilities increased by $371 or 19.5% in 2011 mainly due to increases in accounts payable attributable to the timing of payments and growth of program expenditures of $183 and timing of AHS' long-term debt repayments of $141. Other increases to current liabilities included an increase in deferred operating contributions and accrued vacation pay.

Non-current liabilities are primarily made up of unamortized external capital contributions and deferred capital contributions. Non-current liabilities decreased year over year by only $161 or 2.4%. Within non-current liabilities, deferred capital contributions decreased by $504 in 2011, which was consistent with the increase in capital asset spending from externally restricted funds. The increase in the unamortized external capital contributions balance was also consistent with the decrease in deferred contributions. With respect to long-term debt, the year over year balance increased by $61 in 2011 due to new debt offset by current repayments scheduled for 2011-2012. Non-current liabilities in 2011 also included new provisions for unpaid claims of $77 which offset the overall decrease.

Net assets increased significantly in 2011 by $832 mainly due to Alberta Health and Wellness deficit funding of $527 and an operating surplus excluding deficit funding of $329, partially offset by the transfer of net realized gains on investments to revenue of $21. As at March 31, 2011, AHS has restricted $67 for use at the South Health Campus and for future parkade repairs and construction.

Statement of Financial Position

Working Capital

Working Capital	Actual 2011	Actual 2010	Increase (Decrease)
Total Current Assets	$2,284	$1,386	$898
Total Current Liabilities	$2,272	$1,901	$371
Working Capital Ratio	1.01	0.73	0.28

Working capital ratio is a measure of an entity's liquidity and is defined as current assets divided by current liabilities. A ratio greater than 1.0 indicates that AHS if required could repay all its current liabilities by liquidating its current assets. In 2011, the improved working capital ratio was mainly due to higher levels of cash and cash equivalents which strengthened the balance sheet compared to 2010.

A portion of current liabilities are attributable to capital expenditures which are funded by restricted funds held in non-current cash and investments and capital contributions receivable. AHS receives its monthly funding in advance on the first of the month and invests the cash to maximize investment income until required to meet its current obligations.

Capital Assets

Capital Assets	Actual 2011	Actual 2010	Increase (Decrease)
Cost	$10,852	$9,902	$950
Accumulated amortization	$4,145	$3,751	$394
Net book value	$6,707	$6,151	$556

The total unamortized capital assets as at March 31, 2011 consist of $125 of land and land improvements, $3,882 of facilities, $734 of equipment and building service equipment, $216 of information systems, $81 of leased facilities and improvements and $1,669 of work in progress. The work in progress consists of $654 for the South Health Campus, $311 for the University of Alberta Hospital Edmonton Clinic, $123 for the Rockyview General Hospital expansion, $102 for the South Health Campus parkade, $53 for the Fort Saskatchewan Health Centre, $37 for the Strathcona County Hospital, $33 for the Foothills Medical Centre expansion, $28 for the ER/Ambulatory Care Expansion, $21 for the Grey Nuns Women's Health, and $307 for other capital expenditures.

The estimated remaining useful life for equipment and information systems decreased from 3.2 years to 3.0 years; the estimated useful life for facilities decreased from 21.8 years to 19.6 years in 2011. The capital purchases compared to the annual amortization expense indicates the rate of reinvestment; the reinvestment rate for equipment and information systems was 146% in 2011 (2010 – 86%) and for facilities was 262% in 2011 (2010 – 514%).

Equipment purchased in 2011 amounted to $202 and was funded 47% externally and 53% internally (2010 equipment purchases of $175 were funded 79% externally and 21% internally). Facility purchased in 2011 amounted to $539 and was funded 87% externally and 13% debt-funded (2010 facility purchases of $805 were funded 88% externally, 1% internally and 11% debt-funded). Information systems purchased in 2011 amounted to $180 and was funded 24% externally and 76% internally (2010 information systems purchases of $42 were funded 100% externally). AHS relies significantly on external sources for funding capital expenditures.

AHS has approved capital commitments of $115 for facilities and improvements, $80 for information systems and $110 for equipment.

Statement of Cash Flows

The following table summarizes the Consolidated Statement of Cash Flows:

Consolidated Statement of Cash Flows	2011 Budget	2011 Actual	Variance	2010 Actual	Increase (Decrease)
Operating activities	$924	$957	$33	$(172)	$1,129
Investing activities	(951)	(418)	533	(230)	(188)
Financing activities	384	205	(179)	235	$(30)
Increase (decrease) in current cash and cash equivalents	$357	$744	$387	$(167)	$911
Current cash and cash equivalents, beginning of year	977	977	0	1,144	$(167)
Current cash and cash equivalents, end of year	$1,334	$1,721	$387	$977	$744

The cash position, comprised of cash and temporary investments, has increased to $1721 from $977 in 2010. This increase is primarily the result of the following:

Cash generated from (used by) operating activities relate to the inflow and outflow of cash from the organization's internal activities. The net amount of operating cash flows is derived by adjusting the surplus or deficiency of revenues over expenses to reverse non-cash items like amortization expense, write down of capital assets, amortization of external capital contributions and any changes in non-cash working capital balances.

Operating net cash inflows of $ 957 in 2011 were slightly higher as compared to budget of $924 and also higher as compared to 2010 mainly due to the deficit funding and operating surplus offset slightly by lower cash flows from change in non-cash working capital.

Cash generated from (used by) investing activities relate to the inflow and outflow of cash from transactions associated with the acquisition or sale of non-current assets. Activities that affect investing cash flows include the purchase and sale of capital assets and investments, as well as any allocations related to non-current cash.

Investing net cash outflows of $418 in 2011 were lower as compared to budgeted outflows of $951 mainly as a result of significantly lower capital purchases in 2011 and higher allocations from non-current cash, partially offset by increased purchases of investments in 2011.

The increase in 2011 investing net cash outflows by $188 as compared to the prior year was also mainly due to higher investment purchases, offset by significantly higher allocations from non-current cash.

Cash generated from (used by) financing activities relate to the inflow and outflow of cash from external activities that mainly relate to debt and net assets.

Financing net cash inflows in 2011 were $179 lower than budget mainly due to less capital contributions received in 2011 as well as $59 in capital contributions returned in the current year.

Financing cash flows in 2011 decreased by 12.8% or $30 compared to prior year. The main driver of this decrease was the $59 of capital contributions returned in the current year.

Financial Reporting

2010-11 was the second year for AHS as an entity.

Alberta Health Services (AHS) was established under the Regional Health Authorities Act (Alberta). Effective April 1, 2009, the name of East Central Health was amended to Alberta Health Services (AHS). All other Regional Health Authorities, the Alberta Mental Health Board, the Alberta Cancer Board and the Alberta Alcohol and Drug Abuse Commission were disestablished and amalgamated with AHS. All assets, liabilities, rights and obligations of the disestablished entities were assumed by AHS. During 2010-2011 AHS assumed the operations and administration of Correctional Health Services in Provincial Correctional Institutions and the fixed wing and other rotary air ambulance services within the province of Alberta. During the third quarter of 2011, AHS transitioned to Alberta Infrastructure the construction management of twenty capital projects work in progress currently underway as well as future capital projects that have a value in excess of $5.

The AHS consolidated financial statements have been prepared in accordance with Canadian generally accepted accounting principles and the reporting requirements of Alberta Health and Wellness Financial Directive 4. The chart of accounts that AHS uses to report expenses by program and by object is based on the national standard of the Canadian Institute of Health Information (CIHI). Detailed site based results are submitted to CIHI annually for analysis on Canada's health system and the health of Canadians.

The Public Sector Accounting Board of the CICA (PSAB) has issued a framework for financial reporting by government not-for-profit organizations. The framework includes the 4400 series of standards from the CICA Handbook – Accounting, which have been incorporated into the Public Sector Accounting (PSA) Handbook as PS 4200 series of standards. This framework will be effective for fiscal periods beginning on or after January 1, 2012. Government not-for-profit organizations have been given the choice to apply either PS 4200 series of standards plus the PSA Handbook, or PSA Handbook without the PS 4200 series of standards.

AHS will adopt a framework effective April 1, 2012. However, AHS has not yet decided which option it will adopt and therefore the impact of this framework cannot be determined. AHS will identify the differences in the standards that will impact the financial statements and quantify the differences. AHS will also determine whether any of the specific exemptions and exceptions applicable to the first time adoption of PSA standards by government organizations will be applicable to AHS.

AHS quarterly and annual financial reports are available at www.albertahealthservices.ca under publications.

The Auditor General is the appointed auditor of AHS. In addition to expressing an audit opinion on the AHS annual consolidated financial statements, the Auditor General also reports to the legislature significant recommendations related to AHS along with other government entities. The Auditor General's reports are available at www.oag.ab.ca under public reports.

Outlook into Fiscal 2011-12

Fiscal 2011-12 will mark the second year of the provincial government's five-year funding agreement. This funding commitment will enable AHS to continue to stabilize and strengthen its operations, workforce, and allow continued planning over a long term time horizon.

The 2010-11 provincial government budget increased the allocation to AHS by funding at the level at which it was operating in 2009-10. The provincial government also increased base funding by 6% for each of the years 2010-11, 2011-12 and 2012-13; and by 4.5% for each of the remaining 2 years. In addition one time funding was provided to address the 2009-10 accumulated deficit. Overall, this process provides AHS with the funding stability to make long-term plans, while continuing to maintain budget control.

The 2011-12 focus will target on key priorities as identified in the AHS Health Plan and joint 5 Year Health Action Plan with Alberta Health & Wellness. Priorities such as reducing emergency department wait times, access to surgical services and cancer therapies wait times, and the continued implementation of AHS' Continuing Care Capacity Plan are the main investment areas for 2011-12. However, providing a complex array of quality health services tailored to individual and population needs generates significant inherent risks to maintaining a balanced budget. AHS is committed to providing these services and mitigating financial risks. The current successes of AHS in the merger of back office systems, realized savings and cost avoidance demonstrate the long term commitment to the organization's sustainability.

Given that the AHW base funding is AHS' primary source of revenue, the five-year funding agreement with the Province mitigates a significant portion of the overall revenue risks.

The AHS expense budget is comprised largely of human resource costs, arising from both staff salaries and benefits, as well as contracted health service provider staff. Negotiated collective agreements are in place for United Nurses of Alberta (UNA) and Alberta Union of Provincial Employees (AUPE) Auxiliary Nursing. These contracts contain budget provisions matching the contracted increases and therefore there are no rate risks related to these two contracts. However, the UNA contract increase is expected to be offset by productivity improvements. The timing and ability to implement these productivity improvements in 2011/2012 does pose a financial risk to AHS. The collective agreements with the Health Sciences Association of Alberta (HSAA) and AUPE General Support Services (AUPE GSS) are currently being negotiated and therefore pose further financial risk. These risks will attempt to be mitigated through the collective bargaining process. The risks associated with the expenses for contracted health service providers will be managed and mitigated through the introduction of activity-based funding over a number of years, which started in 2010-11 with the introduction to long-term care facilities. This will improve transparency of funding and tie funding to activity.

Overall, AHS is striving to improve the health status of Albertans, while also improving value.

Consolidated Financial Statements

Alberta Health Services

CONSOLIDATED FINANCIAL STATEMENTS

MARCH 31, 2011

Alberta Health Services

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Alberta Health Services

MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING

MARCH 31, 2011

The accompanying consolidated financial statements for the year ended March 31, 2011 are the responsibility of management and have been reviewed and approved by senior management. The consolidated financial statements were prepared in accordance with Canadian Generally Accepted Accounting Principles and the financial directives issued by Alberta Health and Wellness, and of necessity include some amounts based on estimates and judgment.

To discharge its responsibility for the integrity and objectivity of financial reporting, management maintains a system of internal accounting controls comprising written policies, standards and procedures, a formal authorization structure, and satisfactory processes for reviewing internal controls. This system provides management with reasonable assurance that transactions are in accordance with governing legislation and are properly authorized, reliable financial records are maintained, and assets are adequately safeguarded.

Alberta Health Services carries out its responsibility for the consolidated financial statements through the Audit and Finance Committee. This Committee meets with management and the Auditor General of Alberta to review financial matters, and recommends the consolidated financial statements to the Alberta Health Services Board for approval upon finalization of the audit. The Auditor General of Alberta has free access to the Audit and Finance Committee.

The Auditor General of Alberta provides an independent audit of the consolidated financial statements. His examination is conducted in accordance with Canadian Generally Accepted Auditing Standards and includes tests and procedures which allow him to report on the fairness of the consolidated financial statements prepared by management.

[Original signed by Dr. Chris Eagle]
Dr. Chris Eagle
President and Chief Executive Officer
Alberta Health Services

[Original signed by Chris Mazurkewich]
Chris Mazurkewich
Executive Vice President and Chief Financial Officer
Alberta Health Services

June 10, 2011

AUDITOR GENERAL *Alberta*

Independent Auditor's Report

To the Members of the Alberta Health Services Board
and the Minister of Health and Wellness

Report on the Consolidated Financial Statements

I have audited the accompanying consolidated financial statements of Alberta Health Services, which comprise the consolidated statement of financial position as at March 31, 2011, and the consolidated statements of operations, changes in net assets and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with Canadian generally accepted accounting principles, and for such internal control as management determines is necessary to enable the preparation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on these consolidated financial statements based on my audit. I conducted my audit in accordance with Canadian generally accepted auditing standards. Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion

In my opinion, the consolidated financial statements present fairly, in all material respects, the financial position of Alberta Health Services as at March 31, 2011, and the results of its operations and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

[Original signed by Merwan N. Saher, CA]
Auditor General

June 10, 2011

Edmonton, Alberta

CONSOLIDATED STATEMENT OF OPERATIONS FOR THE YEAR ENDED MARCH 31, 2011

	2011		2010
	Budget (Schedule 3)	Actual	Actual (Note 21)
Revenue:			
Alberta Health and Wellness contributions			
Unrestricted ongoing	$ 9,037,311	$ 9,037,311	$ 7,712,855
Unrestricted deficit funding (Note 4)	527,235	527,235	343,000
Restricted	735,680	747,830	795,747
Other government contributions	97,972	100,893	102,529
Fees and charges	611,980	621,481	577,644
Ancillary operations	112,404	112,367	120,330
Donations	29,646	28,574	20,383
Investment and other income (Note 5)	288,730	292,119	261,331
Amortized external capital contributions (Note 14)	370,329	364,181	305,054
TOTAL REVENUE	11,811,287	11,831,991	10,238,873
Expenses:			
Inpatient acute nursing services	2,664,563	2,584,209	2,523,169
Emergency and outpatient services	1,265,973	1,220,870	1,150,680
Facility-based continuing care services	852,608	844,753	806,303
Ambulance services	364,395	343,034	326,319
Community-based care	768,382	800,256	706,667
Home care	404,054	402,375	381,523
Diagnostic and therapeutic services	1,909,167	1,861,589	1,796,378
Promotion, prevention and protection services	296,125	289,508	303,728
Research and education	214,659	214,253	215,859
Administration (Note 6)	374,726	307,342	381,663
Information technology	385,315	387,655	293,490
Support services	1,478,968	1,521,754	1,427,440
Amortization of facilities and improvements	202,352	198,238	147,338
Write down of capital assets (Note 9(d))	-	-	2,682
Funded transition costs	-	-	13,804
TOTAL EXPENSES (Schedule 1)	11,181,287	10,975,836	10,477,043
Operating surplus (deficiency) of revenue over expenses	$ 630,000	$ 856,155	$ (238,170)

The accompanying notes and schedules are part of these consolidated financial statements.

CONSOLIDATED STATEMENT OF FINANCIAL POSITION AS AT MARCH 31, 2011

	2011 Actual	2010 Actual (Note 21)
ASSETS		
Current:		
Cash and cash equivalents (Note 8)	$ 1,721,465	$ 977,216
Accounts receivable	201,293	166,807
Contributions receivable from Alberta Health and Wellness	200,313	79,233
Inventories	99,097	108,339
Prepaid expenses	61,646	54,903
	2,283,814	1,386,498
Non-current cash and investments (Note 8)	599,335	999,614
Capital contributions receivable from Alberta Health and Wellness	11,476	4,372
Capital assets (Note 9)	6,707,464	6,151,112
Other assets (Note 10)	214,546	233,188
TOTAL ASSETS	$ 9,816,635	$ 8,774,784
LIABILITIES AND NET ASSETS		
Current:		
Accounts payable and accrued liabilities	$ 1,136,937	$ 953,357
Accrued vacation pay	385,525	367,187
Deferred contributions (Note 11)	595,292	567,732
Current portion of long-term debt (Note 13)	153,799	12,938
	2,271,553	1,901,214
Deferred contributions (Note 11)	163,725	163,250
Deferred capital contributions (Note 12)	541,856	1,046,140
Long-term debt (Note 13)	182,500	262,766
Unamortized external capital contributions (Note 14)	5,598,973	5,254,711
Other liabilities (Note 15)	97,454	18,431
	8,856,061	8,646,512
Net assets:		
Accumulated surplus (deficit)	115,741	(527,235)
Accumulated net unrealized gains (losses) on investments	(9,110)	17,243
Other internally restricted net assets (Note 16)	66,722	-
Internally restricted net assets invested in capital assets	777,071	628,114
Operating net assets	950,424	118,122
Endowments (Note 17)	10,150	10,150
	960,574	128,272
TOTAL LIABILITIES AND NET ASSETS	$ 9,816,635	$ 8,774,784

Commitments and contingencies (Note 18)

The accompanying notes and schedules are part of these consolidated financial statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET ASSETS FOR THE YEAR ENDED MARCH 31, 2011

	2011							2010
	Accumulated surplus (deficit)	Accumulated net unrealized gains/ (losses) on investments	Other internally restricted net assets (Note 16)	Internally restricted net assets invested in capital assets	Sub-total operating net assets	Endowments (Note 17)	Total	Total
Balance at beginning of year	$ (527,235)	$ 17,243	$ -	$ 628,114	$ 118,122	$ 10,150	$ 128,272	$ 320,790
Operating surplus (deficiency) of revenue over expenses	856,155	-	-	-	856,155	-	856,155	(238,170)
Capital assets purchased with internal funds	(244,694)	-	-	244,694	-	-	-	-
Amortization of internally funded capital assets	105,905	-	-	(105,905)	-	-	-	-
Repayment of long-term debt used to fund capital assets	(7,880)	-	-	7,880	-	-	-	-
Net repayment of life lease deposits	212	-	-	(212)	-	-	-	-
Purchase of land	-	-	-	2,500	2,500	-	2,500	5,723
Transfer of other internally restricted net assets	(66,722)	-	66,722	-	-	-	-	-
Net unrealized gain (losses) arising during the period on investments	-	(5,074)	-	-	(5,074)	-	(5,074)	39,382
Transfer of net realized losses (gains) on investments to revenue	-	(21,279)	-	-	(21,279)	-	(21,279)	(4,402)
Reclassification adjustments	-	-	-	-	-	-	-	4,949
Balance at end of year	$ 115,741	$ (9,110)	$ 66,722	$ 777,071	$ 950,424	$ 10,150	$ 960,574	$ 128,272

The accompanying notes and schedules are part of these consolidated financial statements.

CONSOLIDATED STATEMENT OF CASH FLOWS FOR THE YEAR ENDED MARCH 31, 2011

	2011		2010
	Budget (Note 3)	Actual	Actual (Note 21)
Operating activities:			
Operating surplus (deficiency) of revenue over expenses	$ 630,000	$ 856,155	$ (238,170)
Non-cash transactions:			
Amortization expense, loss on disposal and write down (Schedule 1)	479,000	470,511	411,585
Amortized external capital contributions	(371,000)	(364,606)	(305,357)
Other	31,000	(2,503)	(147,554)
Changes in non-cash working capital	155,000	(2,169)	107,095
Cash generated from (used by) operating activities	924,000	957,388	(172,401)
Investing activities:			
Purchase of capital assets:			
Internally funded equipment	(65,000)	(107,612)	(36,097)
Internally funded information systems	(135,000)	(137,082)	-
Internally funded facilities and improvements	-	-	(7,103)
Externally funded equipment	(25,000)	(94,365)	(139,317)
Externally funded information systems	(70,000)	(43,331)	(42,256)
Externally funded facilities and improvements	(1,210,000)	(467,154)	(708,985)
Debt funded facilities and improvements	(96,000)	(71,353)	(89,107)
Purchase of investments	(775,000)	(7,343,537)	(341,196)
Proceeds on sale of investments	787,000	5,995,607	412,688
Allocations from non-current cash and investments	925,000	1,774,562	775,595
Changes in non-cash working capital	(287,000)	76,458	(53,911)
Other	-	-	(329)
Cash used by investing activities	(951,000)	(417,807)	(230,018)
Financing activities:			
Capital contributions received	300,000	202,923	160,992
Capital contributions returned	-	(58,850)	-
Proceeds from long-term debt	96,000	73,160	88,830
Principal payments on long-term debt	(12,000)	(12,565)	(14,410)
Cash generated from financing activities	384,000	204,668	235,412
Net increase (decrease) in current cash and cash equivalents	357,000	744,249	(167,007)
Current cash and cash equivalents, beginning of year	977,000	977,216	1,144,223
Current cash and cash equivalents, end of year	$ 1,334,000	$ 1,721,465	$ 977,216

The accompanying notes and schedules are part of these consolidated financial statements

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
MARCH 31, 2011

Note 1 Authority, Purpose and Operations

Alberta Health Services (AHS) was established under the *Regional Health Authorities Act* (Alberta). Effective April 1, 2009, the name of East Central Health was amended to Alberta Health Services (AHS). All other Regional Health Authorities, the Alberta Mental Health Board, the Alberta Cancer Board and the Alberta Alcohol and Drug Abuse Commission were disestablished and amalgamated with AHS. All assets, liabilities, rights and obligations of the disestablished entities were assumed by AHS.

Effective July 15, 2010, the operations and administration of Correctional Health Services in Provincial Correctional Institutions within the province of Alberta were transitioned from the Solicitor General and Minister of Public Security to AHS. The Consolidated Statement of Operations includes $11,435 related to health services in provincial correctional institutions.

Effective October 1, 2010, the operations and administration of fixed wing and other rotary air ambulance services within the province of Alberta were transitioned to AHS. The Consolidated Statement of Operations includes $22,168 related to fixed wing and other rotary air ambulance services.

AHS is responsible in Alberta to:

- promote and protect the health of the population and work toward the prevention of disease and injury;
- assess on an ongoing basis the health needs of the population;
- determine priorities in the provision of health services and allocate resources accordingly;
- ensure reasonable access to quality health services; and
- promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities.

AHS's operations include the facilities and sites listed in the AHS annual report. AHS is a registered charity under the *Income Tax Act* (Canada) and is exempt from the payment of income tax.

Note 2 Significant Accounting Policies and Reporting Practices

(a) Basis of Presentation

The financial statements have been prepared in accordance with Canadian Generally Accepted Accounting Principles and the reporting requirements of Alberta Health and Wellness (AHW) Financial Directive 4.

(i) These financial statements have been prepared on a consolidated basis. Included in these consolidated financial statements are the following wholly owned subsidiaries:

Note 2 Significant Accounting Policies and Reporting Practices (continued)

- Calgary Laboratory Services Ltd. (CLS), who provides medical diagnostic services in Calgary and southern Alberta.
- Capital Care Group Inc. (CCGI), who manages continuing care programs and facilities in the Edmonton area.
- Carewest, who manages continuing care programs and facilities in the Calgary area.

The transactions between AHS and these subsidiaries have been eliminated on consolidation. These entities of AHS are exempt from the payment of income tax.

(ii) AHS uses the proportionate consolidation method to account for its 50% interest in the Northern Alberta Clinical Trials Centre joint venture with the University of Alberta (Note 19(a)(i)), and its 50% interest in the Primary Care Networks disclosed in Note 19 (b).

(iii) AHS consolidates its interest in the Provincial Health Authorities of Alberta Liability and Property Insurance Plan (LPIP). AHS has the majority of representation on the LPIP's governance board and is therefore considered to control the LPIP. The main purpose of LPIP is to share the risks of general and professional liability to lessen the impact on any one subscriber. LPIP is exempt from the payment of income tax but is subject to the Alberta provincial premium tax.

(iv) These consolidated financial statements do not include the assets, liabilities and operations of controlled foundations (Note 19 (c)), voluntary or private facilities providing health services in the Province (Note 19(d)), or the Health Benefits Trust of Alberta (Note 19(e)). These consolidated financial statements do not include trust funds administered on behalf of others (Note 20).

(b) Revenue Recognition

These consolidated financial statements have been prepared using the deferral method of accounting for contributions; the key elements of AHS's revenue recognition policies are:

(i) Unrestricted contributions are recognized as revenue in the year receivable.

(ii) Externally restricted non-capital contributions are deferred and recognized as revenue in the year the related expenses are incurred.

(iii) Externally restricted capital contributions are recorded as deferred capital contributions until invested in capital assets. Amounts expended, representing externally funded capital assets, are then transferred to unamortized external capital contributions. Unamortized external capital contributions are recognized as revenue in the year the related amortization expense of the funded capital asset is recorded.

(iv) Contributions receivable from AHW and capital contributions receivable from Alberta Health and Wellness are recorded as receivable when confirmed with AHW.

(v) Pledges receivable from foundations are recorded as receivable when amounts to be received can be reasonably estimated and ultimate collection is reasonably assured.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(vi) Externally restricted contributions to purchase capital assets that will not be amortized and endowments are treated as direct increases to net assets.

(vii) Investment income includes dividend and interest income, and realized gains or losses on the sale of investments. Unrealized gains and losses on available for sale investments are included directly in net assets or deferred contributions as appropriate, until the related investments are sold. Unrealized gains and losses on held for trading investments are included in the Consolidated Statement of Operations. Restricted investment income is recognized as revenue in the year in which the related expenses are incurred. Other unrestricted investment income is recognized as revenue when earned.

(viii) Donations and contributions in kind are recorded at fair value when such value can reasonably be determined.

(ix) Revenue from sales of goods and services is recorded in the period that goods are delivered or services are provided.

(c) Full Cost

AHS accounts for all costs of services for which it is responsible. Full cost transactions comprise the following:

(i) Revenue earned by contracted health service providers from AHW designated fees and charges are recorded as AHS's fees and charges. An equivalent amount is recorded as program expenses as this revenue funds part of the cost of AHS's programs.

(ii) AHW payments directly to contracted health service providers are recorded as revenue and an equivalent amount is recorded as program expenses as these payments represent part of the cost of AHS's programs.

(iii) The estimated cost for use of acute care facilities not owned by AHS is recorded as other government contributions and as program expenses, since AHS's contract payments do not include an amount for the use of these facilities.

(iv) The estimated cost for use of non-acute care facilities not owned by AHS and provided to AHS at zero or nominal rent is recorded as other government contributions and as program expenses.

(v) Other assets, supplies and service contributions that would otherwise have been purchased are recorded as revenue and expenses, at fair value at the date of contribution, when a fair value can be reasonably determined. Volunteers contribute a significant amount of time each year to assist AHS in carrying out its programs and services. However, contributed services of volunteers are not recognized as revenue and expenses in the consolidated financial statements because fair value cannot be reasonably determined.

(d) Cash, Cash Equivalents and Investments

Cash and cash equivalents consist of cash on hand, balances with banks and investments in money market securities with original maturities of less than three months.

Current cash and cash equivalents are comprised of both unrestricted and restricted funds. Unrestricted funds are used for general operating purposes or internally funded capital projects.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Restricted funds comprise received but unspent deferred contributions, as well as amounts restricted to fund long-term insurance obligations (Note 8(d)).

Non-current cash and investments consist of cash on hand, balances with banks and investments in fixed income and equities. All non-current cash and investments are restricted and are comprised of received but not spent non-current deferred contributions and deferred capital contributions.

Investments are accounted for in accordance with the accounting policies described in Note 2(f). Transaction costs associated with the acquisition and disposal of investments are capitalized and are included in the acquisition costs or reduce proceeds on disposal. Investment management fees are expensed as incurred. The purchase and sale of investments are accounted for using trade-date accounting.

(e) Inventories

Inventories for consumption or distribution at no charge are valued at lower of cost (defined as moving average cost) and current replacement value. All other inventories are valued at lower of cost (defined as moving average cost) and net realizable value.

(f) Financial Instruments

AHS has classified its financial assets and financial liabilities as follows:

Financial Assets and Liabilities	Classification	Subsequent Measurement and Recognition
Cash and cash equivalents	Held for trading	Measured at fair value with changes in those fair values recognized in the Consolidated Statement of Operations.
Investments	Available for sale	Measured at fair value with changes in fair values recognized in the Consolidated Statement of Changes in Net Assets or deferred contributions until realized, at which time the cumulative changes in fair value are recognized in the Consolidated Statement of Operations.
	Held for trading	Measured at fair value with changes in those fair values recognized in the Consolidated Statement of Operations.
Accounts receivable, contributions and capital contributions receivable from AHW	Loans and receivables	After initial fair value measurement, measured at amortized cost using the effective interest rate method.
Accounts payable and accrued liabilities, long-term debt, provision for unpaid claims and life lease deposits	Other financial liabilities	After initial fair value measurement, measured at amortized cost using the effective interest rate method.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

AHS does not use hedge accounting and is not impacted by the requirements of Canadian Institute of Chartered Accountants (CICA) accounting standard Section 3865 - Hedges. AHS as a not-for-profit organization elected to not apply the standards for embedded derivatives in non-financial contracts. In addition, AHS has elected not to adopt Section 3862 Financial Instruments - Disclosures and Section 3863 Financial Instruments - Presentation, and instead has continued to disclose financial instruments under Section 3861 – Financial Instruments Disclosure and Presentation.

When it is determined that an impairment of a financial instrument classified as available for sale is other than temporary, the cumulative loss that had been recognized directly in net assets or deferred contributions is removed and recognized in the Consolidated Statement of Operations even though the financial asset has not been derecognized. Impairment losses recognized in the Consolidated Statement of Operations for a financial instrument classified as available for sale are not reversed.

The carrying value of current cash and cash equivalents, accounts receivable, contributions and capital contributions receivable from AHW, accounts payable and accrued liabilities approximate their fair value because of the short term nature of these items. Unless otherwise noted, it is management's opinion that AHS is not exposed to significant interest, currency or credit risks arising from its financial instruments.

Further disclosure on financial instruments is provided in Note 2(d) Cash, Cash Equivalents and Investments, Note 13 Long-term Debt and Note 15 Other Liabilities.

(g) Capital Assets

Capital assets and work in progress are recorded at cost. Capital assets and work in progress acquired from other government organizations are recorded at the carrying value of that government organization. Costs incurred by Alberta Infrastructure (AI) to build capital assets on behalf of AHS are recorded by AHS as work in progress and unamortized external capital contributions as AI incurs costs. The threshold for capitalizing new systems development is $250 and major enhancements is $100. The threshold for all other capital assets of $5. All land is capitalized.

Capital assets are amortized over their estimated useful lives on a straight-line basis as follows:

	Useful Life
Facilities and improvements	10-40 years
Equipment	2-20 years
Information systems	3-5 years
Leased facilities and improvements	term of lease
Building service equipment	5-40 years
Land improvements	5-40 years

Work in progress, which includes facilities and improvements projects and development of information systems, is not amortized until after a project is complete. Leases transferring substantially all benefits and risks of capital asset ownership are reported as capital asset acquisitions financed by long-term obligations.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(h) Asset Retirement Obligations

AHS recognizes the fair value of a future asset retirement obligation as a liability in the period in which it incurs a legal obligation associated with the retirement of tangible long-lived assets that results from the acquisition, construction, development, and/or normal use of the assets. AHS concurrently recognizes a corresponding increase in the carrying amount of the related long-lived asset that is amortized over the life of the asset. The fair value of the asset retirement obligation is estimated using the expected cash flow approach that reflects a range of possible outcomes discounted at a credit-adjusted risk-free interest rate.

Subsequent to the initial measurement, the asset retirement obligation is adjusted at the end of each period to reflect the passage of time and changes in the estimated future cash flows underlying the obligation. Changes in the obligation due to the passage of time are recognized as an operating expense using the effective interest method. Changes in the obligation due to changes in estimated cash flows are recognized as an adjustment of the carrying amount of the related long-lived asset that is amortized over the remaining life of the asset.

An asset retirement obligation related to the removal of hazardous material that would be required as part of a capital project is only recognized when there is approval from the Minister of Health and Wellness to proceed with the project.

(i) Employee Future Benefits

Registered Benefit Pension Plan

AHS participates in the following registered benefit pension plans: the Local Authorities Pension Plan (LAPP) and the Management Employee Pension Plan (MEPP). These multi-employer public sector final average plans provide pensions for participants, based on years of service and earnings. Benefits for post-1991 service payable under these plans are limited by the *Income Tax Act* (Canada). As these plans are multi-employer plans and sufficient information is not available, these plans are accounted for on a defined contribution basis.

Other Defined Contribution Pension Plans

AHS sponsors Group Registered Retirement Savings Plans (GRRSPs) for certain employee groups. Under the GRRSPs, AHS matches a certain percentage of any contribution made by plan participants up to certain limits. AHS also sponsors a defined contribution pension plan for certain employee groups where the employee and employer each contribute specified percentages of pensionable earnings. In addition, AHS administers a supplemental defined contribution pension plan for a certain employee group. AHS contributes a specified percentage of an employee's earnings in excess of the limits of the *Income Tax Act* (Canada). These plans provide participants with an account balance at retirement based on the contributions made to the plan and investment income earned on the contributions based on investment decisions made by the participant.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Supplemental Executive Retirement Plans (SERPs)

AHS sponsors three defined benefit SERPs which are funded. These plans cover certain employees and supplement the benefits under AHS's registered plans that are limited by the *Income Tax Act* (Canada). Each plan was closed to new entrants effective April 1, 2009. A majority of the SERPs are final average plans, however, certain participant groups have their benefits determined on a career average basis. Also, some participant groups receive post-retirement indexing similar to the benefits provided under the registered defined benefit pension plans; while others receive non-indexed benefits. The obligations and costs of these benefits are determined annually through an actuarial valuation as at March 31 using the projected benefit method pro-rated on service and management's best estimate assumptions, including a market-related discount rate.

Due to *Income Tax Act* (Canada) requirements, the SERPs are subject to the Retirement Compensation Arrangement (RCA) rules; therefore approximately half the assets are held in a non-interest bearing Refundable Tax Account with the Canada Revenue Agency. The remaining assets of the SERPs are invested in a fixed income portfolio. The net benefit cost of SERPs reported in these financial statements include the current service cost, interest cost on the current service cost and obligations, as well as the amortization of past service cost, initial obligations and net actuarial gains and losses. These amounts are offset by the expected return on the plans' assets.

Past service costs, including the initial obligations of the plans, are amortized on a straight-line basis over the average remaining service lifetime of the relevant employee group. Cumulative net actuarial gains or losses over 10 percent of the greater of the benefit obligation and fair value of the plans' assets, are amortized on a straight-line basis over the average remaining service lifetime of the employee group. When an employee's accrued benefit obligation is fully discharged, all unrecognized amounts associated with that employee are fully recognized in the net benefit cost in the following year.

Supplemental Pension Plan (SPP)

The AHS Board has approved a defined contribution SPP for staff not participating in SERP that supplements the benefits under AHS registered plans that are limited by the *Income Tax Act* (Canada). AHS contributes a certain percentage of an eligible employee's pensionable earnings, excluding pay at risk, in excess of the limits of the *Income Tax Act* (Canada). This plan will provide participants with an account balance at retirement based on the contributions made to the plan and investment income earned on the contributions based on investment decisions made by the participant.

Other Benefits

AHS provides its employees with basic life, accidental death and dismemberment, short term disability, long term disability, extended health, dental and vision benefits through benefits carriers. AHS's contributions are expensed to the extent that they do not relate to discretionary reserves. AHS fully accrues its obligations for employee non-pension future benefits.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(j) Internally Restricted Net Assets Invested in Capital Assets

AHS discloses internally restricted net assets invested in capital assets separately on the Consolidated Statement of Financial Position and Consolidated Statement of Changes in Net Assets. The AHS Board has approved the restriction of net assets equal to the net book value of internally funded capital assets that will be amortized.

(k) Grants for Research and Other Initiatives

AHS awards grants to other organizations for research and other initiatives. The term of the grants range from less than one year to more than one year. AHS records the committed value of the grant awarded as an expense when it has been approved and when the agreement between AHS and the principal investigator has been executed.

(l) Measurement Uncertainty

The consolidated financial statements, by their nature, contain estimates and are subject to measurement uncertainty. Measurement uncertainty exists when there is a significant variance between the recognized or disclosed amount and another reasonably possible amount. The amounts recorded for amortization of capital assets and amortization of external capital contributions are based on the estimated useful life of the related assets. The amounts recorded for asset retirement and employee future benefits obligations are based on estimated future cash flows. As disclosed in Note 15, the provision for unpaid claims is subject to significant management estimates and assumptions. These estimates and assumptions are reviewed periodically. Actual results could differ from the estimates determined by management in these financial statements, and these differences, which may be material, could require adjustment in subsequent reporting periods.

(m) Capital Disclosure

For operating purposes, AHS defines capital as including working capital and unrestricted net assets. For capital purposes, AHS defines capital as including deferred capital contributions, long term debt, unamortized external capital contributions, and internally restricted net assets invested in capital assets.

AHS's objectives for managing capital are:

- In the short term, to safeguard its financial ability to continue to deliver health services; and
- In the long term, to plan and build sufficient physical capacity to meet future needs for health services.

The majority of AHS's operating funds are from AHW. AHW provides the operating funds on the first of each month. AHS monitors and forecasts its working capital and cash flow as part of its ongoing cash management activities.

AHW approves health care facilities based on long-term capital plans and Alberta Infrastructure (AI) provides the majority of the funding through one-time capital grants. AHS funds the required equipment and systems by a combination of allocating a portion of operating funds and obtaining external funding from charitable donations and capital grants. AHS borrows to finance capital investments related to ancillary operations, which includes parking and rental operations, non-patient food services and the sale of goods and services, since AHW and AI do not fund ancillary operations.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

AHS complied with all debt covenants during the year. In the event of default, the entire outstanding indebtedness secured by and payable to Alberta Capital Financing Authority (ACFA), at their option, becomes due and payable forthwith and without notice to AHS. ACFA may also elect to retain all or any part of the collateral in satisfaction of the indebtedness of AHS. AHS monitors and forecasts all debt covenants as part of its ongoing debt management activities.

Where AHS has incurred an accumulated deficit, legislation requires submission of a deficit elimination plan.

(n) Changes to Accounting Framework

The Public Sector Accounting Board of the CICA (PSAB) has issued a framework for financial reporting by government not-for-profit organizations. The framework includes the 4400 series of standards from the CICA Handbook – Accounting, which have been incorporated into the Public Sector Accounting (PSA) Handbook as PS 4200 series of standards. This framework will be effective for fiscal periods beginning on or after January 1, 2012. Government not-for-profit organizations have been given the choice to apply either PS 4200 series of standards plus the PSA Handbook, or PSA Handbook without the PS 4200 series of standards. AHS will adopt a framework effective April 1, 2012. However, AHS has not yet decided which option it will adopt and therefore the impact of this framework cannot be determined. AHS will identify the differences in the standards that will impact the financial statements and quantify the differences. AHS will also determine whether any of the specific exemptions and exceptions applicable to the first time adoption of PSA standards by government organizations will be applicable to AHS.

Note 3 Budget

A preliminary business plan with a budgeted surplus of $630,000 was approved by the Board on June 29, 2010 and the full financial plan was submitted to the Minister of Health and Wellness. The reported budget reflects the original $630,000 surplus and additional reclassifications required for more consistent presentation with current and prior year results (Schedule 3).

Note 4 Unrestricted Deficit Funding

AHS started on April 1, 2009 with an opening accumulated deficit of $343,219 from the former health entities. In February 2010 the five-year funding commitment for health was announced including funding the accumulated deficit of AHS after the first year of operations in two phases: $343,000 in 2009-2010 and $527,235 in 2010-2011.

The Consolidated Statement of Operations reports the operating surplus (deficit) including the deficit funding. The operating surplus (deficit) excluding the deficit funding is as follows:

	2011	2010
Operating surplus (deficiency)	$ 856,155	$ (238,170)
Less: Deficit funding	(527,235)	(343,000)
Operating surplus (deficit) excluding deficit funding	$ 328,920	$ (581,170)

Note 5 Investment and Other Income

	2011	2010
Investment income	$ 55,936	$ 25,480
Other income	236,183	235,851
	$ 292,119	$ 261,331

Note 6 Administration Expense

	2011	2010
General administration	$ 90,627	$ 134,397
Human resources	90,119	120,813
Finance	62,598	66,577
Administration- contracts with health service providers	63,998	59,876
	$ 307,342	$ 381,663

Note 7 Pension Expense

	2011	2010
Registered benefit pension plans (a)	$ 322,009	$ 300,513
Costs to transfer employees to LAPP	-	33,000
Defined contribution pension plans and Group RRSPs	12,922	10,850
Supplemental Executive Retirement Plans	3,351	4,233
Supplemental Pension Plan	458	476
	$ 338,740	$ 349,072

(a) Registered Benefit Pension Plans

AHS participates in the Local Authorities Pension Plan (LAPP) and the Management Employee Pension Plan (MEPP), which are multi-employer defined benefit plans. The pension expense recorded in these consolidated financial statements is equivalent to AHS's contributions to the plan during the year as determined by LAPP and MEPP. At December 31, 2010 LAPP reported a deficiency of $4,635,250 (2009 - deficiency of $3,998,614), and MEPP reported a deficiency of $397,087 (2009 – deficiency of $483,199).

Note 8 Cash, Cash Equivalents and Investments

	2011		2010	
	Fair Market Value	Cost	Fair Market Value	Cost
Cash	$ 457,951	$ 457,951	$ 1,552,995	$ 1,552,995
Money market securities	614,132	614,132	65,101	65,095
Fixed income securities	1,220,750	1,230,108	251,528	247,374
Equities	27,967	25,678	107,206	94,123
	$ 2,320,800	$ 2,327,869	$ 1,976,830	$ 1,959,587
Classified as:				
Current				
Unrestricted	$ 1,170,910		$ 313,663	
Restricted	550,555		663,553	
	1,721,465		977,216	
Non-current				
Restricted(d)	599,335		999,614	
	$ 2,320,800		$ 1,976,830	

In order to earn optimal financial returns at an acceptable level of risk, AHS has established an investment bylaw with maximum asset mix ranges of 0% to 100% for cash and money market securities, 0% to 80% for fixed income securities, and 0% to 40% for equities. Risk is reduced through asset class diversification, diversification within each asset class, and quality constraints on fixed income securities and equity investments.

(a) Interest Rate Risk

AHS manages the interest rate risk exposure of its fixed income investments by management of average duration and laddered maturity dates.

Money market securities are comprised of Government of Canada treasury bills maturing June 2011 and bearing interest at an average effective yield of 0.74% (2010 – 0.22%) per annum.

Fixed income securities, such as bonds, have an average effective yield of 2.07% (2010 – 3.70%) per year, maturing between 2011 and 2044. The securities have the following maturity structure:

	2011	2010
1 – 5 years	88%	42%
6 – 10 years	9%	30%
Over 10 years	3%	28%

(b) Currency Rate Risk

AHS is exposed to foreign exchange fluctuations on its investments denominated in foreign currencies. However, this risk is managed by the fact that AHS's investment bylaw limits non-Canadian equities to 25% of the total investment portfolio. As at March 31, 2011, investments in non-Canadian equities represented 0.57% (2010 – 4.55%) of total investments.

Note 8 Cash, Cash Equivalents and Investments (continued)

(c) Credit and Market Risks

AHS is exposed to credit risk from the potential non-payment of accounts receivable. However, the majority of the value of AHS's receivables are from AHW; therefore credit risk is considered to be minimal.

AHS's investment bylaw restricts the types and proportions of eligible investments, thus mitigating AHS's exposure to market risk. Money market securities are limited to a rating of R1 or equivalent or higher and no more than 10% may be invested in any one issuer. Investments in corporate bonds are limited to BBB or equivalent rated bonds or higher and no more than 40% of the total fixed income securities. Investments in debt and equity of any one issuer are limited to 5% of the issuer's total debt and equity. Short selling is not permitted.

(d) Restricted Funds for Long Term Insurance Obligations

Included in restricted cash are cash and investments held by AHS to meet long term liability and property insurance obligations. Amounts totaling $85,386 are restricted as provision for unpaid claims and include an amount to satisfy the reserve and guarantee funds under the *Insurance Act* (Alberta).

Note 9 Capital Assets

	2011			2010
	Cost	Accumulated Amortization	Net Book Value	Net Book Value
Facilities and improvements	$ 6,001,129	$ 2,118,659	$ 3,882,470	$ 3,135,415
Work in progress	1,669,214	-	1,669,214	1,824,049
Equipment	1,740,142	1,160,474	579,668	542,220
Information systems	757,329	541,302	216,027	266,082
Building service equipment	349,066	194,307	154,759	168,688
Land	108,830	-	108,830	106,330
Leased facilities and improvements	162,892	81,900	80,992	90,576
Land improvements	63,512	48,008	15,504	17,752
	$ 10,852,114	$ 4,144,650	$ 6,707,464	$ 6,151,112

(a) Leased Land

Land at the following sites has been provided to AHS at nominal values:

Site	Leased from	Lease expiry
Alberta Children's Hospital	University of Calgary	2101
Banff Health Unit	Mineral Springs Hospital	2028
Cross Cancer Institute parkade	University of Alberta	2019
Foothills Medical Centre parkade	University of Calgary	2054
McConnell Place North	City of Edmonton	2035
Northeast Community Health Centre	City of Edmonton	2048

Note 9 Capital Assets (continued)

(b) Work in Progress

During the year, the responsibility for building the following capital assets was transferred to Alberta Infrastructure (AI) (Note 19(a)(ii)):

- Edson Regional Hospital
- Grande Prairie Regional Health Complex
- High Prairie Health Complex
- Medicine Hat Regional Hospital Redevelopment
- Lethbridge Chinook Regional Hospital
- Sherwood Park Strathcona Hospital – Phase 1
- Fort Saskatchewan Health Centre
- Edmonton Clinic South
- Alberta Hospital Edmonton Food Service Depot
- South Calgary Health Campus
- Bow Island Health Centre (Capital for Emergent Projects)
- Central Alberta Cancer Centre (Red Deer)
- Grande Prairie QEII Emergency Department Redevelopment and Endoscopy Suite
- Lloydminster Dr. Cooke Extended Care Centre
- Fort McMurray Community Health Centres (Thickwood and Timberlea)
- Stollery Childrens Hospital Emergency Department Expansion
- Stollery Childrens Hospital Paediatric Surgical Suite and Inter-operative Magnetic Resonance Imaging Renovations
- Foothills Medical Centre-McCaig Tower Renovations
- Sturgeon Community Hospital Expansion (St. Albert)
- Northern Lights Health Centre Emergency Room Renovations and Ambulatory Care Upgrade (Capital for Emergent Projects) (Fort McMurray)

AHS recorded the costs incurred by AI for these capital assets of $105,966 for the year ended March 31, 2011 as additions to work in progress and capital contributions received in kind (Note 12).

(c) Leased Equipment

Equipment includes assets acquired through capital leases at a cost of $12,250 (2010 - $11,283) with accumulated amortization of $10,938 (2010 - $10,415).

(d) Write-Down of Capital Assets

During the prior year AHS discontinued operations of the Raymond Care Centre and Picture Butte Municipal Hospital, and recorded a write-down of $2,682 to reduce the facilities' carrying value to their fair market value.

Note 10 Other Assets

	2011	2010
Long-term care partnerships – loans (Note 11 (a))	$ 122,739	$ 93,904
Capital contributions receivable	77,600	126,089
Other non-current assets	14,207	13,195
	$ 214,546	$ 233,188

Note 11 Deferred Contributions

Deferred contributions represent unspent externally restricted resources. Changes in the deferred contributions balance are as follows:

	2011			2010
	AHW	Others	Total	Total
Balance beginning of the year	$ 373,262	$ 357,720	$ 730,982	$ 811,971
Received during the year	801,985	145,969	947,954	892,186
Restricted investment income	1,703	4,387	6,090	3,164
Transferred from (to) deferred capital contributions	(20,924)	23,047	2,123	(4,475)
Recognized as revenue	(747,829)	(180,303)	(928,132)	(971,864)
Balance end of the year	$ 408,197	$ 350,820	$ 759,017	$ 730,982

Note 11 Deferred Contributions (continued)

The balance at the end of the year is restricted for the following purposes:

	2011			2010
	AHW	Others	Total	Total
Current				
Mental Health and Safe Communities	$ 107,364	$ 1,225	$ 108,589	$ 129,901
Research and education	2,926	73,792	76,718	73,279
Physician revenue and Alternate Relationship Plans	53,618	857	54,475	39,184
Continuing care and seniors health	49,128	2,461	51,589	22,609
Virtual site training for Calgary South Health Campus	49,630	-	49,630	-
Cancer prevention and research	30,780	15,567	46,347	51,680
Primary Care Networks (Note 19(b))	41,940	-	41,940	41,826
Promotion, prevention and community	27,159	13,470	40,629	34,800
Infrastructure maintenance	-	37,305	37,305	46,548
Emergency and outpatient services	5,306	7,357	12,663	13,849
Inpatient acute nursing services	3,497	9,061	12,558	10,089
Diagnostic and therapeutic services	6,992	5,131	12,123	15,617
Pandemic	8,619	-	8,619	8,613
Healthy Workforce Action Plan	-	7,595	7,595	11,128
Information technology	7,028	232	7,260	11,086
Telehealth	5,791	79	5,870	7,422
EMS transition	5,655	-	5,655	18,318
Support services	284	3,805	4,089	5,402
Wait times	-	-	-	9,898
Regional Shared Health Information Program	-	-	-	8,090
Others less than $5,000	2,480	9,158	11,638	8,393
	408,197	187,095	595,292	567,732
Non-current:				
Long term care partnerships [(a)]	-	159,691	159,691	157,435
Other	-	4,034	4,034	5,815
	-	163,725	163,725	163,250
	$ 408,197	$ 350,820	$ 759,017	$ 730,982

Note 11 Deferred Contributions (continued)

(a) Long-term care partnership agreements

AHS has entered into partnership with voluntary and private health service providers to build and operate long-term care facilities within Alberta. The Government of Alberta has supported these partnerships through providing one-time, up-front capital funding to enable AHS and the voluntary and private partners to develop the approved infrastructure. Two partnership models have been used for the payment of the grant from AHS to the partnership organizations; the Supplementary Payment Model and the Forgivable Mortgage Model.

Under the Supplementary Payment Model, AHS makes annual payments to the partner over the term of the partnership contract, which is usually the expected useful life of the infrastructure. Amounts invested under the terms of long-term care partnership agreements will be utilized to fund future payments to providers over the next 22 years. These payments have a net present value of $20,695 at March 31, 2011 (2010 - $26,067) discounted at 3.7% (2010 – 3.0%). The amounts invested under the terms of the long-term care partnership agreements have a market value at March 31, 2011 of $29,654 (2010 - $37,020). AHS is subject to risk to meet the payment obligations as they become due.

AHS recognizes the supplementary payment expenses in facility-based continuing care services on the Consolidated Statement of Operations and recognizes an equal amount of revenue as other government contributions from deferred contributions long-term care partnership projects. Investment income earned, net of management fees, is recorded as an increase to both the investment base and the deferred contribution.

Under the Forgivable Mortgage Model, AHS provides a loan to the partner who uses the funds to construct the infrastructure. AHS does not accrue interest on the loan as AHS intends to forgive the balance of the loan in accordance with the agreement. The loan is repayable on demand in the event of default and is secured by the facility. The loan is considered an asset as it is recoverable from services rendered by the owner over the life of the agreement.

AHS amortizes the long-term care partnership project asset (Note 10) on a straight line basis over the useful life of the infrastructure to facility-based continuing care services on the Consolidated Statement of Operations and recognizes an equal amount of revenue as other government contributions from deferred contributions long-term care partnership projects.

Note 12 Deferred Capital Contributions

Deferred capital contributions represent unspent externally restricted resources related to capital assets. Changes in the deferred capital contributions balance are as follows:

	2011				2010
	AHW	AI	Others	Total	Total
Balance beginning of the year	$230,031	$763,983	$ 52,126	$1,046,140	$1,696,776
Received or receivable during the year	74,365	39,227	43,165	156,757	236,457
Received in kind	-	105,966	86	106,052	-
Restricted investment income	965	-	-	965	272
Capital contributions returned	(5,469)	(53,000)	(381)	(58,850)	-
Transferred to unamortized external capital contributions	(93,504)	(582,305)	(35,006)	(710,815)	(891,148)
Transferred from (to) deferred contributions	20,924	(23,025)	(22)	(2,123)	4,475
Other	(12,705)	16,435	-	3,730	(692)
Balance end of the year	$ 214,607	$ 267,281	$ 59,968	$ 541,856	$1,046,140

Note 12 Deferred Capital Contributions (continued)

The balance at the end of the year is restricted for the following purposes

	2011				2010
	AHW	AI	Others	Total	Total
Facilities and improvements:					
Infrastructure maintenance projects	$ -	$ 143,009	$ -	$ 143,009	$ 158,031
Capital escalation	-	-	-	-	63,658
North Treatment Centre	-	-	5,674	5,674	33,708
Stollery Pediatric Emergency Expansion	-	-	5,000	5,000	-
The Edmonton Clinic					102,731
South Calgary Hospital	-	-	-	-	93,548
Rockyview General Hospital	-	-	-	-	35,909
Peter Lougheed Centre	-	-	-	-	22,045
Foothills Medical Clinic	-	-	-	-	18,702
Other initiatives		124,272	18,139	142,411	271,850
	-	267,281	28,813	296,094	800,182
Information systems:					
Regional Shared Health Information Program	44,979	-	-	44,979	36,851
Diagnostic Imaging Project Year 3	29,004	-	-	29,004	33,201
Diagnostic Imaging Project Year 4	26,219	-	-	26,219	-
Provincial Health Information Exchange	10,909	-	-	10,909	14,477
Others less than $10,000	75,971	-	-	75,971	82,179
Equipment	27,525	-	31,155	58,680	79,250
	$ 214,607	$ 267,281	$ 59,968	$ 541,856	$ 1,046,140

Note 13 Long-term Debt

		2011		2010
Debentures payable: [a]				
Parkade loan #1	$	46,683	$	48,747
Parkade loan #2		42,303		44,020
Parkade loan #3		51,582		53,332
Parkade loan #4		15,000		5,000
Parkade loan #5		5,000		-
Calgary Laboratory Services purchase		16,583		22,697
Term loan-Parkade #4 [b]		138,000		83,000
Term loan-Parkade #5 [c]		2,000		-
Obligation under capital lease [d]		15,328		16,042
Other		3,820		2,866
	$	336,299	$	275,704
Current	$	153,799	$	12,938
Non-current		182,500		262,766
	$	336,299	$	275,704
Fair value of total long-term debt [e]	$	345,325	$	282,242

(a) AHS issued debentures to Alberta Capital Financing Authority (ACFA), a related party, to finance the construction of parkades and the purchase of the remaining 50.01% ownership interest in CLS. AHS has pledged as security for these debentures revenues derived directly or indirectly from the operations of all parking facilities being built, renovated, owned and operated by AHS.

As at March 31, 2011, $15,000 (2010 - $5,000) of $181,000 has been advanced to AHS relating to the Parkade loan #4 debenture with the remaining to be drawn by September 1, 2011. Semi-annual principal and interest payments of $7,165 will commence March 1, 2012.

As at March 31, 2011, $5,000 (2010 - $NIL) of $42,300 has been advanced to AHS relating to the Parkade loan #5 debenture with the remaining to be drawn by June 1, 2012. Semi-annual principal payments of $1,577 will commence December 1, 2012.

The maturity dates and interest rates for the debentures are as follows:

	Maturity Date	Interest Rate
Parkade loan #1	September 2026	4.4025%
Parkade loan #2	September 2027	4.3870%
Parkade loan #3	March 2029	4.9150%
Parkade loan #4	September 2031	4.9250%
Parkade loan #5	June 2032	4.2280%
Calgary Laboratory Services purchase	May 2013	4.6810%

(b) AHS obtained a term loan facility of $181,000 during 2010, of which $138,000 (2010 - $83,000) has been drawn at March 31, 2011. The facility has been secured by the issuance of the Parkade #4 debenture to ACFA. Although the loan is repayable on demand, repayment terms are for monthly payment of interest only at an average rate of 2.241%, with the full principal repayment due upon maturity on September 1, 2011. Management does not believe that the demand features of the callable debt will be exercised in the current period.

Note 13 Long-term Debt (continued)

(c) AHS obtained a term loan facility of $42,300 during 2011, of which $2,000 has been drawn at March 31, 2011. The facility has been secured by the issuance of the Parkade #5 debenture to ACFA. Although the loan is repayable on demand, repayment terms are for monthly payment of interest only at 3.22%, with the full principal repayment due upon maturity on June 1, 2012. Management does not believe that the demand features of the callable debt will be exercised in the current period.

(d) The capital lease with the University of Calgary expires January 2028. The implicit interest rate payable on this lease is 6.5%.

(e) The fair value of long-term debt is estimated based on market interest rates from ACFA for debentures of similar maturity.

(f) As at March 31, 2011 AHS held a $220,000 revolving demand facility with a Canadian chartered bank which may be used for operating purposes. Draws on the facility bear interest at the bank's prime rate less 0.5% per annum. As at March 31, 2011, AHS has no draws against this facility.

AHS also holds a $33,000 revolving demand letter of credit facility which may be used to secure AHS's obligations to third parties relating to construction projects. As at March 31, 2011, AHS had $6,024 (2010 - $4,305) in letters of credit outstanding against this facility.

AHS is committed to making payments as follows:

Year ended March 31	Debentures Payable, Term/Other Loan and Mortgages Payable Principal payments	Capital Lease Minimum lease payments
2012	$ 153,113	$ 1,660
2013	21,286	1,464
2014	17,347	1,453
2015	14,533	1,453
2016	15,221	1,453
Thereafter	301,611	18,298
	$ 523,111	25,781
Less: interest		10,453
		$ 15,328

During the year, the amount of interest expensed was $7,954 (2010 - $8,845).

Note 14 Unamortized External Capital Contributions

Unamortized external capital contributions at year-end represent the external capital contribution to be recognized as revenue in future years. Changes in the unamortized external capital contributions balance are as follows:

	2011	2010
Balance beginning of year	$ 5,254,711	$ 4,675,230
Transferred from deferred capital contributions	710,815	891,148
Transfer of land to investment in capital assets	(2,500)	(5,723)
Less amounts recognized as revenue:		
Amortized external capital contributions- Equipment	(129,551)	(118,341)
Amortized external capital contributions- Information systems	(52,326)	(52,117)
Amortized external capital contributions- Facilities and improvements	(182,304)	(134,596)
Amortization – Ancillary operations	(425)	(259)
Other	553	(631)
Balance end of year	$ 5,598,973	$ 5,254,711

Note 15 Other Liabilities

	2011	2010
Provision for unpaid claims [(a)]	$ 76,802	$ -
Life lease deposits [(b)]	12,815	12,603
Asset retirement obligations [(c)]	10,409	10,713
Accrued benefit (asset) liability of SERPs [(d)]	(12,511)	(6,180)
Other	9,939	1,295
	$ 97,454	$ 18,431

(a) Provision for Unpaid Claims

Provision for unpaid claims represents the losses from identified claims likely to be paid and provisions for liabilities incurred but not yet reported. The establishment of the provision for unpaid claims relies on the judgment and opinions of many individuals, on historical precedent and trends, on prevailing legal, economic, and social and regulatory trends, and on expectation as to future developments. The process of determining the provision necessarily involves risks that the actual results will deviate perhaps materiality from the best estimates made.

The fair value of unpaid claims is not practicable to determine with sufficient reliability. Under accepted actuarial practice, the appropriate value of the claims liabilities is the discounted value of such liabilities plus the provision for adverse deviation. The provision for unpaid claims has been estimated using the discounted value of claim liabilities using a discount rate of 3.25%.

Note 15 Other Liabilities (continued)

(b) Life Lease Deposits

Funding for the Laurier House facilities, a project for long-term care residents in Edmonton, is provided by the tenants with a non-interest bearing repayment deposit, for the right to occupy the unit they are leasing. When the life lease agreement is terminated, which may be by death of the tenant or the tenant moving out, the life lease deposit is returned to the tenant without interest and in accordance with the terms of the Life Lease Agreement. The liability for life lease deposits is based on a discharge rate of 25% (2010 – 25%) and a discount rate of 2.2% (2010 - 2.0%), representing the bank secured lending rate. The reported liability is based on estimates and assumptions with respect to events extending over a 4 year period using the best information available to management. The carrying value of the reported liability approximates the fair value.

(c) Asset Retirement Obligation

The asset retirement obligation (ARO) represents the legal obligation associated with the removal of asbestos during planned renovations of AHS facilities. The total undiscounted amount of the estimated cash flows required to settle the recorded obligation is $11,151 (2010 - $11,474), which has been discounted using a weighted average credit-adjusted risk free rate of 2.2% (2010 - 2.1%). Payments to settle the ARO are expected to occur by 2014. AHS has identified the existence of asbestos in other buildings which is not required to be remediated at this time and therefore is not recorded as an obligation.

Note 15 Other Liabilities (continued)

(d) Supplemental Executive Retirement Plans

During the year there were three SERPs sponsored by AHS. Under the terms of the three SERPs, participants will receive retirement benefits that supplement the benefits under AHS's registered plans that are limited by the *Income Tax Act* (Canada). As required under the plans' terms, any unfunded obligations identified in the actuarial valuation completed at the end of each fiscal year must be fully funded within 61 days. The accounting policies for SERPs are described in Note 2 (i).

	2011	2010
Change in accrued benefit obligation		
Accrued benefit obligation, beginning of year	$ 31,809	$ 28,715
Current service cost	1,668	1,701
Interest cost	1,754	2,000
Benefit payments	(2,159)	(3,224)
Actuarial losses	1,071	2,617
Accrued benefit obligation, end of year	$ 34,143	$ 31,809
Change in plan assets		
Fair value of plan assets, beginning of year	$ 32,367	$ 10,178
Adjustment to opening value	(984)	-
Actual return on plan assets	1,189	510
Actual employer contributions	9,682	24,903
Benefit payments	(2,159)	(3,224)
Fair value of plan assets, end of year	$ 40,095	$ 32,367
Reconciliation of funded status to accrued benefit asset/liability		
Funded status of the plan	$ 5,952	$ 558
Unrecognized net actuarial losses	5,921	4,334
Unrecognized initial obligations	342	512
Unrecognized past service cost	296	776
Accrued benefit asset (liability), end of year	$ 12,511	$ 6,180

Note 15 Other Liabilities (continued)

	2011	2010
Determination of net benefit cost		
Current service cost	$ 1,668	$ 1,701
Interest cost	1,754	2,000
Actual return on assets	(1,189)	(510)
Actuarial losses (gains) in year	87	2,617
Amortization of initial obligations	392	264
Difference between expected and actual return on assets	302	224
Difference between recognized and actual actuarial gains/losses	79	(2,468)
Difference between recognized and actual past service Costs	258	405
Net benefit cost	$ 3,351	$ 4,233
Members		
Active	60	64
Retired and terminated	48	55
Total members	108	119
Assumptions		
Weighted average discount rate to determine year end obligations	4.90%	5.40%
Weighted average discount rate to determine net benefit costs	5.40%	6.38%
Expected return on assets	2.70%	2.70%
Expected average remaining service life time	5	5
Rate of compensation increase per year	2011-2012 1.5% 2012-2013 2.5% Thereafter 3.5%	2010-2011 1.5% 2012-2014 3.2% Thereafter 3.5%

Note 16 Other Internally Restricted Net Assets

	2011	2010
South Health Campus [(a)]	$ 50,000	$ -
Parkade infrastructure reserve [(b)]	16,722	-
	$ 66,722	$ -

(a) The AHS Board has approved the restriction of $50,000 (2010 - $NIL) to assist with funding start up costs for South Health Campus in Calgary.

(b) The AHS Board has approved the restriction of $16,722 (2010 - $NIL) from parking services surpluses to establish a parking infrastructure reserve for future major maintenance, upgrades and construction.

Note 17 Endowments

		2011		2010
Cancer Research Institute of Alberta Director Research Chair [(a)]	$	10,000	$	10,000
J.K. Bigelow Education Fund [(b)]		150		150
	$	10,150	$	10,150

(a) The Cancer Research Institute of Alberta (CRIA) Director Research Chair endowment is internally restricted and is designated for use as a Research Chair for the Director of CRIA. The principal amount of $10,000 is required to be maintained and all investment proceeds are available for use. Investment proceeds from the fund are used for the salary, infrastructure and operating grant support for the CRIA Director Research Chair.

(b) The J.K. Bigelow Education Fund endowment is internally restricted and is designated for funding of health related courses undertaken by employees of AHS in the Lethbridge area. The principal amount of $150 is required to be maintained and all investment proceeds are available for use. Investment proceeds from the fund are used for education.

Note 18 Commitments and Contingencies

(a) Leases

AHS is contractually committed to future operating lease payments for premises and vehicles until 2029 and 2017 respectively as follows:

		Premises		Vehicles		Total
2012	$	47,673	$	2,877	$	50,550
2013		34,927		1,858		36,785
2014		26,366		1,180		27,546
2015		22,811		648		23,459
2016		16,521		136		16,657
Thereafter		36,468		15		36,483
	$	184,766	$	6,714	$	191,480

(b) Capital Assets

AHS has the following outstanding contractual commitments for capital assets as of March 31:

		2011
Facilities and improvements	$	114,758
Information systems		79,500
Equipment		110,232
	$	304,490

(c) Contracted Health Service Providers

AHS contracts on an ongoing basis with voluntary and private health service providers to provide health services in Alberta as disclosed in Note 19 (d). AHS has contracted for services in the year ending March 31, 2012 similar to those provided by these providers in 2011.

Note 18 Commitments and Contingencies (continued)

(d) Contingencies

As at March 31, 2011 AHS is named as a defendant in 361 legal claims (2010 – 368 legal claims). 314 of these claims have specified amounts totalling $325,490 and the remaining 47 have no specified amounts. (2010 – 321 claims with specified amounts of $678,474 and 47 with no specified amounts). Included in the total legal claims are 30 claims amounting to $215,253 (2010 – 7 claims amounting to $93,965) in which AHS has been jointly named with other government entities.

AHS has been named as a defendant in a legal action in respect of increased long-term care accommodation charges levied effective August 1, 2003. The claim has been filed against the Government of Alberta and the former Regional Health Authorities (now AHS). The amount of the claim has not been specified but has been estimated to be between $100 million and $175 million per year based on the amount of the increase in accommodation charges levied, which came into effect August 1, 2003. The outcome of the claim is not determinable and no liability is recorded at this time.

AHS has a contingent liability in respect of claims relating to the failure of St. Joseph's Hospital to provide adequate infection control and safety measures to prevent contamination of medical equipment. The total amount of these claims is in excess of $25 million. The outcome of the claims is not determinable, and no liability is recorded at this time.

Included in Other Liabilities (Note 15(a)) is $19,488 representing claims identified and likely to be paid and $57,314 representing claims to be paid but not yet identified.

The restricted cash and investments described in Note 8(d), are available to fund future payments of certain losses. AHS can access these funds subject to a maximum limit of $5 million per occurrence with an additional $5 million limit per occurrence. The additional limit is subject to an absolute limit of $15 million in aggregate for all occurrences for each policy year. Claims in excess of these limits are to be funded by AHS's unrestricted funds. AHS does not purchase any reinsurance.

Note 19 Related Parties

Transactions with the following related parties are considered to be in the normal course of operations. Amounts due to or from the related parties and the recorded amounts of the transactions are included within these consolidated financial statements, unless otherwise stated.

(a) Government of Alberta

The Minister of Health and Wellness appoints the AHS Board members. AHS is economically dependent on AHW since the viability of its operations depend on contributions from AHW. Transactions between AHS and AHW are reported and disclosed in the Consolidated Statement of Operations, the Consolidated Statement of Financial Position, and the Notes to the Consolidated Financial Statements.

Note 19 Related Parties (continued)

AHS shares a common relationship and is considered to be a related party with those entities consolidated or included on a modified equity basis in the Province of Alberta's financial statements. Transactions in the normal course of operations between AHS and the other ministries are recorded at their exchange amount as follows:

	Revenue		Expenses	
	2011	2010	2011	2010
Ministry of Advanced Education (i)	$ 24,298	$ 24,098	$ 121,472	$ 115,045
Ministry of Infrastructure (ii)	4,614	87	539	391
Other ministries	28,579	24,821	19,630	22,029
Total for the year	$ 57,491	$ 49,006	$ 141,641	$ 137,465

	Receivable from		Payable to	
	2011	2010	2011	2010
Ministry of Advanced Education (i)	$ 5,396	$ 2,662	8,891	$ 14,887
Ministry of Infrastructure (ii)	39,227	-	12,951	3
Other ministries	9,630	7,462	180,572	177,445
Balance at end of the year	$ 54,253	$ 10,124	$ 202,414	$ 192,335

(i) Most of AHS transactions with the Ministry of Advanced Education relate to initiatives with the University of Alberta and the University of Calgary. These initiatives include teaching, research, and program delivery. A number of physicians are employed by either AHS or the universities but perform services for both. Due to proximity of locations, some initiatives result in sharing physical space and support services. The revenue and expense transactions are a result of grants provided from one to the other and recoveries of shared costs.

(ii) During the year, AHS signed an agreement effective June 17, 2010 transferring to AI responsibility for management of major capital projects greater than $5,000. As a result, AHS transferred to AI $113,000 of unspent funds from deferred capital contributions and responsibility for twenty projects currently in progress. AHS also transferred future obligations on the twenty projects related to contractual commitments of $977,928. AHS retained title to work in progress and recorded costs incurred by AI as non-cash capital contributions and additions to work in progress (Note 9(b)).

Note 19 Related Parties (continued)

(b) Primary Care Networks

AHS has joint control with various physician groups over Primary Care Networks (PCNs). AHS entered into local primary care initiative agreements to jointly manage and operate the delivery of primary care services, to achieve the PCN business plan objectives, and to contract and hold property interests required in the delivery of PCN services. Both parties have equal share ownership and equal Board representation. The Primary Care Initiative Committee (PCIC) was established under the tri-lateral agreement between AHS, AHW and Alberta Medical Association (the "parties") to provide strategic direction as well as facilitate the achievement of key objectives of PCNs. The parties have equal representation on PCIC. As a requirement of the PCIC, PCNs can only use accumulated surpluses based on an approved surplus reduction plan, and as such, AHS's proportionate share of these surpluses has been recorded by AHS as restricted deferred contributions. The following PCNs are included in these consolidated financial statements under the proportionate consolidation method:

Alberta Heartland Primary Care Network
Athabasca Primary Care Network
Big Country Primary Care Network
Bonnyville / Aspen Primary Care Network
Bow Valley Primary Care Network
Calgary Foothills Primary Care Network
Calgary Rural Primary Care Network
Calgary West Central Primary Care Network
Camrose Primary Care Network
Chinook Primary Care Network
Cold Lake Primary Care Network
Edmonton North Primary Care Network
Edmonton Oliver Primary Care Network
Edmonton Southside Primary Care Network
Edmonton West Primary Care Network
Grande Prairie Primary Care Network
Highland Primary Care Network
Leduc Beaumont Devon Primary Care Network
Lloydminster Primary Care Network
McLeod River Primary Care Network
Mosaic Primary Care Network
Northwest Primary Care Network
Palliser Primary Care Network
Peace River Primary Care Network
Provost/Consort Primary Care Network
Red Deer Primary Care Network
Rocky Mountain House Primary Care Network
Sexsmith/Spirit River Primary Care Network
Sherwood Park-Strathcona County Primary Care Network
South Calgary Primary Care Network
St. Albert & Sturgeon Primary Care Network
St. Paul / Aspen Primary Care Network
Vegreville Primary Care Network
Vermilion Primary Care Network
West Peace Primary Care Network
WestView Primary Care Network
Wolf Creek Primary Care Network
Wood Buffalo Primary Care Network

Note 19 **Related Parties (continued)**

AHS's proportionate share of assets, liabilities, revenues and expenses, and cash flows of the PCNs is as follows:

	March 31, 2011	March 31, 2010
Assets:		
Current	$ 43,110	$ 42,872
Non-current	4,029	4,484
Total assets	$ 47,139	$ 47,356
Liabilities:		
Current [(i)]	$ 47,139	$ 47,356
Total liabilities	47,139	47,356
Total revenue	$ 67,531	$ 56,785
Total expenses	67,531	56,785
	$ -	$ -

(i) Included in current liabilities are deferred contributions of $41,940 (2010 - $41,826) (Note 11).

(c) Foundations

A large number of foundations provide donations of money and services to AHS to enhance health care in various communities throughout Alberta. This financial support to AHS is reflected in donations revenue and capital contributions. These foundations are registered charities under the *Income Tax Act* (Canada) and accordingly, are exempt from income taxes, provided certain requirements of the Income Tax Act are met.

(i) Controlled foundations

A number of foundations are considered to be controlled entities as AHS appoints all trustees for such foundations. Controlled foundations are not consolidated in these financial statements.

Note 19 **Related Parties (continued)**

The Alberta Cancer Foundation (ACF) and the Calgary Health Trust (CHT) are the most significant controlled foundations. The following aggregated financial results of ACF and CHT is presented using the same accounting policies as AHS:

	2011		2010	
	ACF	CHT	ACF	CHT
Revenue	$ 43,872	$ 40,634	$ 27,263	$ 59,456
Expenses	43,276	39,670	29,420	58,146
Operating surplus (deficiency) of revenue over expenses	$ 596	$ 964	$ (2,157)	$ 1,310
Total assets	$ 118,248	$ 87,572	$ 95,634	$ 88,448
Total liabilities(1) (2)	43,227	64,406	28,835	68,670
Net assets(1) (2)	$ 75,021	$ 23,166	$ 66,799	$ 19,778

(1) In accordance with donor imposed restrictions ACF must maintain permanently $72,577 (2010 - $65,502) with the investment revenue earned to be used for purposes in accordance with the various purposes established by the donors or the Trustees. A further $40,780 (2010 - $27,380) included in liabilities are deferred contributions that must be used for the purpose of cancer research, prevention and screening initiatives, as well as patient care and support, education and equipment.

(2) In accordance with donor imposed restrictions CHT must maintain permanently $19,880 (2010 - $16,441) with the investment revenue earned to be used in accordance with the various purposes established by the donors or the Board. A further $53,371 (2010 - $59,989) included in liabilities are deferred contributions that must be used for the purpose of capital projects and medical equipment, patient care and program support and medical research.

Financial information for the remaining controlled foundations is not disclosed because AHS does not receive financial information from all these foundations on a timely basis and the cost and effort of preparing financial information for disclosure exceeds the benefit of doing so. These foundations' financial statement balances are immaterial individually and in aggregate relative to AHS. The following are the remaining foundations controlled by AHS as at March 31, 2011:

Bassano and District Health Foundation
Bow Island and District Health Foundation
Brooks and District Health Foundation
Canmore and Area Health Care Foundation
Cardston and District Health Foundation
Claresholm and District Health Foundation
Crowsnest Pass Health Foundation
David Thompson Health Region Trust
Fort Macleod and District Health Foundation
Fort Saskatchewan Community Hospital Foundation
Grande Cache Hospital Foundation
Grimshaw/Berwyn Hospital Foundation
Jasper Health Care Foundation
Medicine Hat and District Health Foundation
Mental Health Foundation
North County Health Foundation
Oyen and District Health Care Foundation
Stettler Health Services Foundation
Strathcona Community Hospital Foundation
Tofield and Area Health Services Foundation
Viking Health Foundation
Windy Slopes Health Foundation

Note 19 Related Parties (continued)

The following foundations are also considered controlled, but are in the process of being wound-up or are considered to be inactive:

Central Peace Hospital Foundation
Lakeland Regional Health Authority Foundation
Peace Health Region Foundation
Peace River Community Health Centre Foundation
Manning Community Health Centre Foundation
McLennan Community Health Care Foundation
Vermilion and Region Health and Wellness Foundation

(ii) Other foundations

AHS has an economic interest in a number of foundations as they raise and hold resources to support AHS. AHS appoints one board trustee for such foundations. Financial information for these foundations is not disclosed because AHS does not receive financial information from all these foundations on a consistent and timely basis and the cost and effort of preparing financial information for disclosure exceeds the benefit of doing so. The following are the foundations that AHS has an economic interest in as of March 31, 2011:

Alberta Children's Hospital Foundation
Beaverlodge Hospital Foundation
Black Gold Health Foundation
Capital Care Foundation
Chinook Regional Hospital Foundation
Consort Hospital Foundation
Coronation Heath Centre Foundation
Daysland Hospital Foundation
Devon General Hospital Foundation
Drayton Valley Health Services Foundation
Drumheller Area Health Foundation
Fairview Health Complex Foundation
Glenrose Rehabilitation Hospital Foundation
High River District Health Care Foundation
Hinton Healthcare Foundation
Hythe Nursing Home Foundation
Northern Lights Regional Health Foundation
Northwest Health Foundation
Queen Elizabeth II Hospital Foundation
Red Deer Regional Health Foundation
Regional EMS Foundation
Rosebud Health Foundation
Royal Alexandra Hospital Foundation
Sheep River Health Trust
St. Paul and District Hospital Foundation
Stollery Children's Hospital Foundation
Strathmore District Health Services Foundation
Sturgeon Community Hospital Foundation
Taber and District Health Foundation
Tri-Community Health and Wellness Foundation
University Hospital Foundation
Valleyview Health Complex Foundation
Wainwright and District Community Foundation
Wetaskiwin Health Foundation

The following foundations are in the start-up process and are expected to be operating within the first quarter of fiscal 2012:

Lacombe Hospital and Care Centre Foundation
Ponoka Health Centre Foundation
Vulcan County Health and Wellness Foundation

Note 19 Related Parties (continued)

(d) Contracts with Health Service Providers

AHS is responsible for the delivery of health services in the Province. To this end, AHS contracts with various voluntary and private health service providers to continue to provide health services throughout Alberta. The largest of these service providers is Covenant Health; the total amount funded to Covenant Health during the year was $617,083 (2010 - $551,098). As of March 31, 2011, the net book value of capital assets owned by AHS but operated by a voluntary or private health service provider was $138,036 (2010 - $141,506).

AHS has an economic interest through its contracts with certain voluntary and private health service providers as AHS transfers significant resources as follows:

	2011			2010		
	Voluntary Health Service Providers	Private Health Service Providers	Total	Voluntary Health Service Providers	Private Health Service Providers	Total
Direct AHS funding	$893,259	$857,597	$1,750,856	$816,197	$778,183	$1,594,380
Fees and charges	97,643	96,009	193,652	95,490	94,284	189,774
Full cost adjustments	13,035	83	13,118	14,387	83	14,470
Direct AHW funding	-	643	643	-	986	986
	$1,003,937	$954,332	$1,958,269	$926,074	$873,536	$1,799,610

Included in the Statement of Operations as follows:

Inpatient acute nursing services	$ 265,105	$ 227,760
Emergency and outpatient services	80,183	68,631
Facility-based continuing care services	510,772	493,082
Ambulance services	13,352	-
Community-based care	291,287	241,514
Home care	150,893	145,403
Diagnostic and therapeutic services	296,011	279,466
Promotion, prevention and protection services	7,775	10,269
Research and education	3,902	2,928
Administration	64,005	59,876
Information Technology	497	324
Support services	274,487	270,357
	$ 1,958,269	$ 1,799,610

Note 19 Related Parties (continued)

(e) Health Benefit Trust of Alberta

Effective July 1, 2010, the Health Organization Benefit Plan (HOBP) changed its name to the Health Benefit Trust of Alberta (HBTA) following an amendment to the Trust Agreement. AHS is one of more than thirty participants in HBTA and has a majority of representation on HBTA governance board. The HBTA is a formal health and welfare trust established under a Trust Agreement effective January 1, 2000. HBTA provides health and other related employee benefits pursuant to the authorizing Trust Agreement. HBTA uses various carriers for the different benefits. HBTA is exempt from the payment of income taxes.

Under the terms of the Trust Agreement, no participating employer or eligible employee shall have any right to any surplus or assets of the Trust nor shall they be responsible for any deficits or liabilities of the Trust. HBTA maintains various reserves to adequately provide for all current obligations and reported fund balances of $79,576 as at December 31, 2010 ($29,594 as at December 31, 2009). For the period January 1 to December 31, 2010 AHS paid premiums of $132,121 (2010 - $38,159). Included in prepaid expenses is $44,118 (2010 - $15,824) representing AHS's proportionate share of the HBTA's surpluses at December 31, 2010.

Note 20 Trust Funds

AHS receives funds in trust from AHW that are to be paid to operators of non-owned facilities for capital purposes or facility repairs, and for specific projects. In addition, AHS receives funds in trust for research and development, education and other programs. AHS received funds in trust from AHW for some PCNs; AHS uses these funds to cover the Primary Care Networks' expenditures until they make their own banking arrangements. These amounts are held on behalf of others with no power of appropriation and therefore are not reported in these consolidated financial statements. As at March 31, 2011, the balance of funds held by AHS is as follows:

	2011	2010
AHW	$ -	$ 694
Research and development, education and other programs	7,263	6,558
Primary Care Networks	-	3,943
	$ 7,263	$ 11,195

AHS also receives funds in trust from continuing care residents for personal expenses. These amounts are not included above and not reflected in these consolidated financial statements.

Note 21 Corresponding Amounts

Certain 2010 amounts have been reclassified to conform to the 2011 presentation.

Note 22 Approval of Consolidated Financial Statements

The consolidated financial statements have been approved by the Alberta Health Services Board.

SCHEDULE 1 - CONSOLIDATED SCHEDULE OF EXPENSES BY OBJECT FOR THE YEAR ENDED MARCH 31, 2011

	2011		2010
	Budget (Schedule 3)	Actual	Actual (Note 21)
Salaries and benefits (Schedule 2)	$ 5,803,536	$ 5,667,428	$ 5,483,260
Contracts with health service providers (Note 19 (d))	1,950,034	1,958,269	1,799,610
Contracts under the Health Care Protection Act	20,657	19,308	23,866
Drugs and gases	383,726	361,468	332,600
Medical and surgical supplies	314,113	330,132	320,135
Other contracted services	1,165,268	1,112,310	1,101,908
Other *	1,064,953	1,056,410	1,004,079
Amortization:			
Internally funded equipment	33,000	33,501	45,147
Internally funded information systems	49,000	48,656	36,838
Internally funded facilities and improvements	26,000	24,341	24,474
Externally funded equipment	135,000	129,379	117,792
Externally funded information systems	50,000	50,773	52,117
Externally funded facilities and improvements	185,000	181,420	132,171
Loss on disposal of assets	1,000	2,441	364
Write down of capital assets (Note 9 (d))	-	-	2,682
	$ 11,181,287	$ 10,975,836	$ 10,477,043

* Significant amounts included in Other are:			
Equipment expense	$ 154,172	$ 155,690	$ 127,839
Building and ground expenses	126,717	139,787	138,933
Other clinical supplies	116,455	117,928	119,717
Utilities	115,055	100,614	94,622
Minor equipment purchases	50,562	93,903	73,139
Food and dietary supplies	64,654	67,928	69,733
Housekeeping, laundry and linen, plant maintenance and biomedical engineering supplies	66,319	64,249	64,103
Office supplies	62,110	60,668	79,353
Travel	57,062	48,758	51,379
Building rent	22,194	28,852	26,095
Insurance	17,490	20,646	17,549
Licenses, fees and membership	14,808	17,564	19,124
Education	44,460	13,549	12,026
Other	152,895	126,274	110,467
	$ 1,064,953	$ 1,056,410	$ 1,004,079

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2011

	2011								2010	
						Severance [e]				
	FTE [a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Number of Individuals	Amount	Total	FTE [a]	Total
Total Board	13.37	$ -	$ 706	$ -	$ 706	-	$ -	$ 706	15.00	$ 898
Total Executive	10.98	3,946	1,083	613	5,642	1	661	6,303	11.24	6,230
Management Reporting to CEO Reports	51.29	10,601	2,183	2,922	15,706	4	1,143	16,849	42.78	11,186
Other Management	3,454.45	351,533	13,499	72,957	437,989	74	4,395	442,384	3,472.32	455,079
Medical Doctors not included above	143.68	38,447	1,901	4,309	44,657	-	-	44,657	172.44	42,945
Regulated nurses not included above:										
RNs, Reg. Psych. Nurses, Grad Nurses	16,819.47	1,387,709	164,991	274,950	1,827,650	-	(2,810)	1,824,840	16,764.59	1,825,494
LPNs	3,349.88	196,819	19,826	38,098	254,743	6	221	254,964	3,307.90	236,626
Other Health Technical & Professionals	13,130.73	1,005,958	64,576	204,382	1,274,916	96	4,632	1,279,548	12,580.79	1,168,773
Unregulated Health Service Providers	6,302.33	271,865	20,748	53,812	346,425	56	769	347,194	6,047.78	321,272
Other Staff	21,155.09	1,144,180	51,824	249,642	1,445,646	224	4,337	1,449,983	22,132.96	1,381,757
Costs to transfer employees to LAPP	-	-	-	-	-	-	-	-	-	33,000
Total	**64,431.27**	**$ 4,411,058**	**$ 341,337**	**$ 901,686**	**$ 5,654,080**	**461**	**$ 13,348**	**$ 5,667,428**	**64,547.80**	**$ 5,483,260**

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2011 (CONTINUED)

	Term	2011 Committees	2011 Honoraria	2010 Honoraria
Board Chair				
Ken Hughes(1)	Since May 15, 2008	AF, GOV, HA, HR, QS	$ 91	$ 104
Board Members				
Catherine Roozen(2)	Since Jul 29, 2008	AF, GOV, HA, HR, QS	55	53
Jack Ady	May 15, 2008 to Aug 31, 2010	HR, QS (former Chair)	23	62
Lori Andreachuk	Nov 20, 2008 to Aug 31, 2010	GOV, HA	28	61
Dr. Ray Block(5)	Since Feb 18, 2011	HR	-	-
Gord Bontje	Nov 20, 2008 to Nov 26, 2010	AF, GOV	35	60
Teri Lynn Bougie	Since Nov 20, 2008	HA, QS	52	61
Jim Clifford	Nov 20, 2008 to Aug 31, 2010	AF, HR	23	61
Dr. Ruth Collins-Nakai	Since Feb 18, 2011	HR, QS	6	-
Strater Crowfoot	Nov 20, 2008 to Mar 31, 2011	HA, HR	46	59
Tony Franceschini	Nov 20, 2008 to Nov 24, 2010	AF, GOV	35	58
Dr. Kamalesh Gangopadhyay	Since Oct 13, 2010	GOV, HA, QS	23	-
Linda Hohol	May 15, 2008 to Nov 26, 2010	GOV (former Chair)	34	59
Don Johnson	Since Feb 18, 2011	AF, HA	6	-
Dr. Andreas Laupacis	Nov 20, 2008 to Nov 27, 2010	QS (former Chair)	28	60
John Lehners	Since May 15, 2008	HA (Chair)	52	65
Irene Lewis	Since May 15, 2008	HR (Chair)	49	60
Stephen Lockwood	Since Oct 13, 2010	AF, GOV (Chair), HR	24	-
Don Sieben(3)	Since May 15, 2008	AF(Chair)	64	75
Dr. Eldon Smith	Since Feb 18, 2011	AF, GOV	5	-
Sheila Weatherill(5)	Since Feb 18, 2011	AF, GOV	-	-
Gord Winkel(4)	Since Nov 20, 2008	AF, QS(Chair)	27	-
Total Board			$ 706	$ 898

Board members are compensated with monthly honoraria and honoraria for attendance at board and committee meetings in accordance with Ministerial Order #50. Although M.O. #50 was repealed by M.O. #93, original rates from M.O. #50 were adopted again as of January 1, 2010.

(1) Ken Hughes is Board Chair and Ex-Officio Member on all Committees.
(2) Catherine Roozen is Board Vice Chair and Ex-Officio Member on all Committees.
(3) Don Sieben also received honoraria for serving on the Alberta Hospital Edmonton Implementation Committee from October 20, 2009 to March 31, 2010.
(4) Gord Winkel started to claim honoraria August 2010 following his retirement from Syncrude Canada Ltd.
(5) Ray Block and Sheila Weatherill do not claim honoraria.

Committee legend: AF = Audit and Finance, GOV = Governance, HA = Health Advisory, HR = Human Resources, QS = Quality and Safety

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2011 (CONTINUED)

	2011									
For the Current Fiscal Year	FTE	Base Salary (b)	Pay-at-Risk Component (b)	Other Variable Pay (b)	Vacation Payouts (b)	Other Cash Benefits (c)	Other Non-Cash Benefits (d)	Subtotal	Severance (e)	Total
Board Direct Reports										
President and Chief Executive Officer (f)(k)	0.65	$ 383	$ -	$ 54	$ 29	$ 48	$ 3	$ 517	$ 661	$ 1,178
Acting President and Chief Executive Officer (f)(i)(l)(q)	0.35	167	-	25	43	4	43	282	-	282
Chief Audit Executive (m)(r)	0.76	151	21	-	-	-	18	190	-	190
Interim VP Internal Audit and Enterprise Risk Management - Contracted Services (n)	0.24	113	-	-	-	-	-	113	-	113
Ethics and Compliance Officer (s)	1.00	209	-	-	-	-	35	244	-	244
CEO Direct Reports										
Executive VP and Chief Financial Officer (f)(t)	1.00	370	55	-	-	33	65	523	-	523
Executive VP, Corporate Services (f)(t)	1.00	370	60	-	-	27	60	517	-	517
Executive VP, Quality and Service Improvement (f)(i)(l)(q)	0.65	307	-	49	190	7	79	632	-	632
Executive VP and Acting Executive Lead for Quality and Service Improvement (j)(o)(u)	0.33	159	-	27	-	-	19	205	-	205
Executive VP, Rural, Public and Community Health (h)(v)	1.00	370	-	62	-	1	106	539	-	539
Executive VP, Strategy and Performance (f)(t)	1.00	370	59	-	-	27	59	515	-	515
Executive VP, Clinical Support Services (g)(w)	1.00	365	-	65	16	2	60	508	-	508
Executive VP and Chief Medical Officer (j)(o)(u)	0.67	323	-	52	92	-	40	507	-	507
Acting Executive VP and Chief Medical Officer (p)(s)	0.33	137	16	-	-	-	-	153	-	153
Chief of Staff, Board Office and VP Community Engagement (s)	1.00	152	-	19	-	-	26	197	-	197
Total Executive	10.98	$ 3,946	$ 211	$ 353	$ 370	$ 149	$ 613	$ 5,642	$ 661	$ 6,303

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2011 (CONTINUED)

	2010									
For the Prior Fiscal Year (Note 21)	FTE	Base Salary (b)	Pay-at-Risk Component (b)	Other Variable Pay (b)	Vacation Payouts (b)	Other Cash Benefits (c)	Other Non-Cash Benefits (d)	Subtotal	Severance (e)	Total
Board Direct Reports										
President and Chief Executive Officer	1.00	$ 575	$ -	$ 77	$ -	$ 62	$ 30	$ 744	$ -	$ 744
Interim VP Internal Audit and Enterprise Risk Management - Contracted Services	0.09	42	-	-	-	-	-	42	-	42
VP Internal Audit and Enterprise Risk Management	0.52	120	-	-	31	-	53	204	362	566
VP Internal Audit and Enterprise Risk Management	0.42	82	-	-	3	3	16	104	-	104
Ethics and Compliance Officer	0.98	205	-	-	-	2	42	249	-	249
CEO Direct Reports										
Executive VP and Chief Financial Officer	0.97	359	57	-	-	32	44	492	-	492
Executive VP, Corporate Services	0.74	274	44	-	-	37	38	393	-	393
Acting Executive VP, Corporate Services	0.33	62	-	-	-	-	19	81	-	81
Executive VP, Quality and Service Improvement	1.00	472	-	82	-	29	229	812	-	812
Executive VP, Rural, Public and Community Health	1.00	370	-	60	-	-	91	521	-	521
Executive VP, Strategy and Performance	0.41	152	26	-	-	41	27	246	-	246
Acting Executive VP, Strategy and Performance	0.75	257	-	-	42	60	62	421	61	482
Senior VP, Clinical Support Services	1.00	330	-	47	-	-	49	426	-	426
Senior Physician Executive	1.00	480	-	80	-	6	160	726	-	726
VP Community Engagement and Chief of Board Office	0.37	53	-	6	-	6	13	78	-	78
Chief of Staff, Board Office	0.58	111	-	-	27	6	35	179	-	179
Interim Chief Operating Officer, Health Research and Design	0.08	24	-	-	13	1	51	89	-	89
Total Executive	11.24	$ 3,968	$ 127	$ 352	$ 116	$ 285	$ 959	$ 5,807	$ 423	$ 6,230

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2011 (CONTINUED)

Supplemental Pension Plan (SPP) and Supplemental Executive Retirement Plan (SERP)

	2011					2010			
	SPP		SERP						
	Current Service Costs	Prior Service Costs	Current Service Cost	Other SPP Costs	Total	Total	Account Balance or Accrued Benefit Obligation March 31, 2010	Change During the Year	Account Balance or Accrued Benefit Obligation March 31, 2011
President and Chief Executive Officer	-	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Acting President and Chief Executive Officer/Executive VP, Quality and Service Improvement (l)	-	-	107	65	172	179	1,140	237	1,377
Chief Audit Executive	5	-	-	-	5	-	-	5	5
Interim VP Internal Audit & Enterprise Risk Management - Contracted Services	-	-	-	-	-	-	-	-	-
Ethics and Compliance Officer	7	7	-	-	14	-	-	14	14
Executive VP and Chief Financial Officer	23	23	-	-	46	-	-	46	46
Executive VP, Corporate Services	23	17	-	-	40	-	-	40	40
Executive VP and Acting Executive Lead for Quality and Service Improvement/ Executive VP and Chief Medical Officer (o)	-	-	74	14	88	109	391	208	599
Executive VP, Rural, Public and Community Health	-	-	35	18	53	62	638	87	725
Executive VP, Strategy and Performance	23	9	-	-	32	-	-	32	32
Executive VP, Clinical Support Services	-	-	27	3	30	27	80	214	294
Acting Executive VP and Chief Medical Officer	-	-	-	-	-	-	-	-	-
Chief of Staff, Board Office and VP Community Engagement	1	1	-	-	2	-	-	2	2

Certain employees will receive retirement benefits that supplement the benefits limited under the registered plans for service post 1991. The SPP is a defined contribution plan and the SERP is a defined benefit plan. The SPP costs are AHS contributions in the period. Changes in the account balance include current and prior service costs and investment income. The SERP costs are not cash payments in the period but are the cost for the period for rights to these future retirement benefits. Current service cost is the actuarial present value of the benefits earned in the fiscal year. Other SERP costs include interest cost on the obligations and current service cost, the amortization of past service cost, initial obligations and net actuarial gains and losses, offset by the expected return on the plans' assets. Changes in the accrued benefit obligation include current service cost, interest accruing on the obligations and the current service cost as well as the full amount of any actuarial gains or losses in the period. The SERP is disclosed in Notes 2(i) and 15(d).

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2011 (CONTINUED)

Definitions

a. For this schedule, Full time equivalents (FTE) are determined by actual hours paid divided by 2,022.75 annual base hours. If applicable, FTE for Board Members are prorated using the number of days in the fiscal year between either the date of appointment and the end of the year or the beginning of the year and the termination date. Total actual discrete number of individuals employed during the fiscal year was 99,386 (2010 – 94,715).

b. There are two compensation models for senior leaders. Some receive a base salary with a component that is at risk if they do not meet performance objectives. Others receive a base salary plus other variable pay if they meet performance objectives.

Pay at risk: As new staff is hired or existing contracts end, senior leaders are required to participate in 'pay-at-risk'. Under this model, a component of remuneration is withheld during the year and released (in full or in part) based on achievement of performance objectives.

Other variable pay: The President and Chief Executive Officer and senior leaders with contracts existing prior to formation of AHS may have variable pay provisions in their contracts. Variable pay is in addition to, and calculated as a percentage of, base salary. Variable pay is paid based on achievement of performance objectives.

Vacation payouts, which are a cash benefit, are shown separately for direct reports of the Board or President and Chief Executive Officer. Vacation accruals are included in base salary except for direct reports of the Board or President and Chief Executive Officer where it is included in other non-cash benefits.

c. Other cash benefits may include as applicable honoraria, overtime, automobile allowance, and lump sum payments. For anyone other than direct reports of the Board or the President and Chief Executive Officer, other cash benefits may also include pay at risk or other variable pay if applicable.

d. Other non-cash benefits include:

- Employer's current and prior service cost of supplemental pension plan and supplemental executive retirement plans.
- Share of employee benefits and contributions or payments made on behalf of employees including pension, health care, dental coverage, vision coverage, out-of-country medical benefits, group life insurance, accidental disability and dismemberment insurance, long and short term disability plans.
- Employer's share of the cost of additional benefits including sabbaticals or other special leave with pay.

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2011 (CONTINUED)

e. Severance includes direct or indirect payments to individuals upon termination or voluntary exit which are not included in other cash benefits or non-cash benefits. Severance also includes under or over accruals from the prior year. For example, the current year severance amount for RNs, Reg. Psych. Nurses, and Grad Nurses includes the effect of an over accrual in the prior year for a voluntary exit program. The prior year accrual was based on 488 individuals but during the current year only 362 individuals received a severance payment.

f. Incumbents are provided with an automobile allowance. Dollar amounts are included in other cash benefits.

g. Incumbents are provided with an automobile. Dollar amounts are not included in other non-cash benefits.

h. Incumbent had been provided an automobile for which dollar amounts were not included in other non-cash benefits. Effective March 11, 2011, incumbent is provided an automobile allowance. Dollar amounts are included in other cash benefits.

i. Incumbent is on secondment from the University of Calgary. The incumbent's total remuneration is comprised of salary amounts from both AHS and the University of Calgary. AHS reimburses the University for the incumbent's rank salary, honorarium and market supplements; all amounts have been included in base salary.

j. Incumbent is on secondment from the University of Calgary. The incumbent's total remuneration is comprised of salary amounts from both AHS and the University of Calgary. AHS reimburses the University for the incumbent's rank salary; all amounts have been included in base salary.

Appointments and Departures

k. Position held by incumbent until November 24, 2010. The incumbent received the salary and other accrued entitlements to the date of departure of December 2, 2010 and other variable pay to November 24, 2010. The reported severance includes 12 months base salary at the rate in effect at the date of departure and 15% of the severance in lieu of all other benefits, both in accordance with the incumbent's contract. In addition to the reported severance, the incumbent's contract also allows a relocation expense to be paid not to exceed $20,000. The severance will be paid when the incumbent signs the release. Incumbent's share of other cash benefits included an amount for the maximum contribution to a registered retirement savings plan. The incumbent did not complete five full years of employment and therefore is not entitled to any paid sabbatical leave.

l. Incumbent held the position of Executive Vice President, Quality and Service Improvement until November 24, 2010 at which time the incumbent was appointed to Acting President and Chief Executive Officer. There was no additional compensation for the Acting President and Chief Executive Officer position. Compensation has been allocated to each position based on the time held in each position during the year except that other variable pay has been allocated to each position based on the performance review relating to each position.

m. Incumbent appointed to position effective June 28, 2010.

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2011 (CONTINUED)

n. Position held by incumbent until June 28, 2010.

o. Incumbent held the position of Executive Vice President and Chief Medical Officer until December 2, 2010 at which time the incumbent was appointed to Executive Vice President and Acting Executive Lead for Quality and Service Improvement. There was no additional compensation for the Executive Vice President and Acting Executive Lead for Quality and Service Improvement position. Compensation has been allocated to each position based on the time held in each position during the year except that other variable pay has been allocated to each position based on the performance review relating to each position.

p. Incumbent appointed to position effective December 2, 2010.

Termination Liabilities

q. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive severance pay for a maximum 18 months base salary(i) and premium payments at the rate in effect at the date of termination. The incumbent will also receive the incentive bonus for the prior two years divided by 24 months multiplied by a maximum of 18 months, and up to 18 months of the total cost of the incumbent's benefits. AHS will also make payment for the incumbent to attend an outplacement program for 6 months.

r. In the case of termination without just cause by AHS, the incumbent shall receive severance pay equal to 12 months base salary. This severance payment will be reduced by any employment earnings received from a new employer within the 12 month period.

s. The incumbent's termination benefits have not been predetermined.

t. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive severance pay equal to 12 months base salary at the rate in effect at the date of termination. Such severance will be paid in 12 equal monthly installments. The incumbent will also be paid 15% of the severance in lieu of all other benefits. Upon obtaining alternate employment, the incumbent is only entitled to receive one-half of the unpaid severance at that time.

u. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive severance pay equal to a maximum of 18 months base salary(i) and premium payments at the rate in effect at the date of termination. The incumbent will also be paid an amount up to 18 months of the total cost of the incumbent's benefits. AHS will also make payment for the incumbent to attend an outplacement program for 6 months.

v. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive severance pay equal to 24 months base salary at the rate in effect at the date of termination. The incumbent will also be paid an amount equal to 24 months of AHS's cost of benefits.

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2011 (CONTINUED)

w. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive a severance package equivalent to 12 months salary and benefits plus one additional month per year of service provided to a maximum of 24 months.

x. SPP and SERP

For those who departed within the 2010-2011 fiscal period that are direct reports of the Board or the President and Chief Executive Officer, there were no benefits to be received based on the provisions of the SPP or SERP.

SCHEDULE 3 - CONSOLIDATED SCHEDULE OF BUDGET
FOR THE YEAR ENDED MARCH 31, 2011

	Original Financial Plan (Note 3)	Additional Reclassifications	Reported Budget
Revenue			
Alberta Health and Wellness contributions			
Unrestricted ongoing	$ 9,038,000	$ (689)	$ 9,037,311
Unrestricted deficit funding	527,000	235	527,235
Restricted	745,000	(9,320)	735,680
Other government contributions	81,000	16,972	97,972
Fees and charges	598,000	13,980	611,980
Ancillary operations	123,000	(10,596)	112,404
Donations	20,000	9,646	29,646
Investment and other income	257,000	31,730	288,730
Amortization of external capital contributions	371,000	(671)	370,329
TOTAL REVENUE	11,760,000	51,287	11,811,287
Expenses			
Inpatient acute nursing services	2,681,000	(16,437)	2,664,563
Emergency and outpatient services	1,231,000	34,973	1,265,973
Facility-based continuing care services	871,000	(18,392)	852,608
Ambulance services	353,000	11,395	364,395
Community-based care	747,000	21,382	768,382
Home care	411,000	(6,946)	404,054
Diagnostic and therapeutic services	1,907,000	2,167	1,909,167
Promotion, prevention and protection services	353,000	(56,875)	296,125
Research and education	219,000	(4,341)	214,659
Administration	397,000	(22,274)	374,726
Information technology	344,000	41,315	385,315
Support services	1,414,000	64,968	1,478,968
Amortization of facilities and improvements	202,000	352	202,352
TOTAL EXPENSES	11,130,000	51,287	11,181,287
Operating surplus of revenue over expenses	$ 630,000	$ -	$ 630,000

SCHEDULE 3 - CONSOLIDATED SCHEDULE OF BUDGET FOR THE YEAR ENDED MARCH 31, 2011 (CONTINUED)

	Original Financial Plan (Note 3)	Additional Reclassifications	Reported Budget
Expenses by object			
Salaries and benefits	$ 5,721,000	$ 82,536	$ 5,803,536
Contracts with health service providers	2,027,000	(76,966)	1,950,034
Contracts under the Heath Care Protective Act	24,000	(3,343)	20,657
Drugs and gases	349,000	34,726	383,726
Medical and surgical supplies	340,000	(25,887)	314,113
Other contracted services	1,187,000	(21,732)	1,165,268
Other	1,003,000	61,953	1,064,953
Amortization			
Internally funded equipment	33,000	-	33,000
Internally funded information systems	49,000	-	49,000
Internally funded facilities and improvements	26,000	-	26,000
Externally funded equipment	135,000	-	135,000
Externally funded information systems	50,000	-	50,000
Externally funded facilities and improvements	185,000	-	185,000
Loss on disposal of capital assets	1,000	-	1,000
Write down of capital assets	-	-	-
TOTAL EXPENSES BY OBJECT	$ 11,130,000	$ 51,287	$ 11,181,287

Appendix

- **Surgical Contracts**
- **List of AHS Facilities**
- **AHS Q4 Performance Report**

Surgical Contracts

Non-Hospital Surgical Facility Contracts under the Health Care Protection Act (Alberta)

Alberta Health Services contracts with multiple non-hospital surgical facilities (NHSF) to provide insured surgical services for dermatology, ophthalmology, oral maxillofacial, otolaryngology, plastic surgery, orthopedic and pregnancy terminations. The use of NHSFs enables AHS to obtain quality services to enhance surgical access and alleviate capacity pressures within AHS main operating rooms.

Alberta Health Services determines if the contract is appropriate by assessing sustainability of the public system, access to services, patient safety, appropriateness, effectiveness, cost and public benefit. Contracts with NHSFs provide increased choice of service provider for patients and supplement the resources available in hospitals, while providing good value for public dollars.

The following table summarizes the contracts by service area for 2010/2011.

Service Area	Number of Operators	Number of Procedures Performed
Dermatology	1	23
Ophthalmology	12	18,069
Oral & Maxillofacial Surgery	19	2,623
Orthopedic *(Only in Calgary Zone)*	1	182
Otolaryngology (ENT)	1	622
Plastic Surgery	2	850
Pregnancy Termination	2	10,524
Provincial Total	38	32,893

Surgical contracts with NHSFs are in the Calgary and Edmonton Zones; there are no surgical contracts with NHSFs in the South, Central or North Zones.

List of AHS Facilities as of March 31, 2011

Legend:

Facility Type Abbreviation	Description	Explanation
Addiction	Addiction Treatment Beds / Spaces	Facilities with beds and mats for clients with substance use and gambling problems. Includes detoxification, nursing care, assessment, counseling and treatment. Direct services provided by AHS as well as funded and contracted services. Also includes beds for PChAD (Protection of Children Abusing Drugs) program clients and residential beds funded through the Safe Communities Initiative.
Comm MH	Community Mental Health Beds / Spaces	Mental health support home programs, Canadian Mental Health Association community beds and other mental health community beds/spaces.
Psych	Standalone Psychiatric Facilities	Stand-alone psychiatric facilities: 1. Alberta Hospital Edmonton (Edmonton) 2. Centennial Centre for Mental Health and Brain Injury (CCMHBI) (Ponoka) 3. Claresholm Centre for Mental Health and Addictions (Claresholm) 4. Southern Alberta Forensic Psychiatric Centre (Calgary) 5. Villa Caritas (Edmonton)
Hospital	Hospital	Acute Care Hospitals where active treatment is provided. ED reflects facilities with Emergency Departments and no acute care beds. CA reflects Cancer Care facilities. OP reflects facilities providing ambulatory services.
Sub-Acute	Sub-Acute in an Auxiliary Hospital	Sub acute care provided in Auxiliary Hospital for the purpose of receiving convalescent and/or rehabilitation services, where it is anticipated that they will achieve their functional potential, to enable them to improve their health status and to successfully return to the community.
LTC	Long Term Care	Long term care is provided in nursing homes and auxiliary hospitals. It is reserved for those with unpredictable and complex health needs, usually multiple chronic and/or unstable medical conditions. Long-term care includes health and personal care services, such as 24-hour nursing care provided by registered nurses or licensed practical nurses.
Palliative	Palliative	Facilities where a designated program or bed for the purpose of receiving palliative care services including end of life and symptom alleviation not in an acute care facility. Include community hospice beds.
SL	Supportive Living	Supportive living include comprehensive services such as the availability of 24-hour nursing care (levels 3 or 4). Supportive Living 4-Dementia (SL4D) is also available for those individuals living with moderate to severe dementia or cognitive impairment. Albertans accessing supportive living services generally reside in lodges, retirement communities, or supportive living centres.
Cancer	Cancer Care	Cancer Care Services include: Assessments and examinations, supportive care, pain management, prescription of cancer-related medications, education, resource and support counseling and referrals to other cancer centres.
CACC	Community Ambulatory Care Centre	A community ambulatory care centre (CACC) is a community-based service delivery site (non-hospital setting) primarily engaged in the provision of ambulatory care diagnostic and treatment services. This includes typically scheduled primary care for clients who do not require hospital outpatient emergency care or inpatient treatment.
UCC	Urgent Care Centre	Urgent Care Centre and Advanced Ambulatory Care Centres (AACC) provide assessment, diagnostic and treatment services for unscheduled patients who require immediate medical attention for injuries/illness that require human and technical resources more intensive than what is available in physicians office.

List of AHS Facilities as of March 31, 2011

South Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Sub-Acute	LTC	Palliative	SL	Cancer	CACC	UCC
Crowsnest Pass Health Centre	*	Blairmore				X		X					
York Creek Lodge		Blairmore								X			
Bow Island Health Centre	*	Bow Island				X		X					
Brooks Health Centre	*	Brooks				X		X					
Orchard Manor		Brooks								X			
Sunrise Gardens		Brooks								X			
Cardston Health Centre	*	Cardston				X		X					
Chinook Lodge		Cardston								X			
Coaldale Health Centre	*	Coaldale				X		X					
Sunny South Lodge		Coaldale								X			
Extendicare Fort MacLeod		Fort MacLeod						X					
Foothills Detox Centre		Fort MacLeod	X										
Fort MacLeod Health Centre	*	Fort MacLeod				X							
Pioneer Lodge		Fort MacLeod								X			
Chinook Regional Hospital	*	Lethbridge				X					X		
Columbia House Lethbridge		Lethbridge								X			
Edith Cavell Care Centre		Lethbridge						X					
Extendicare, Fairmont Park		Lethbridge								X			
Golden Acres		Lethbridge								X			
Good Samaritan Park Meadows Village		Lethbridge								X			
Good Samaritan Society, Lee Crest		Lethbridge								X			
Good Samaritan West Highlands		Lethbridge								X			
Legacy Lodge		Lethbridge								X			
South Country Treatment Centre		Lethbridge	X										
Southern Alcare Manor		Lethbridge	X										
St Michael's Health Centre		Lethbridge					X	X	X				
St Michael's Health Centre - St. Therese Villa		Lethbridge								X			
Youth Residential Services	*	Lethbridge	X										
Good Samaritan Garden Vista		Magrath								X			

List of AHS Facilities as of March 31, 2011

South Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Sub-Acute	LTC	Palliative	SL	Cancer	CACC	UCC
Magrath Health Centre	*	Magrath										X	
Club Sierra		Medicine Hat						X					
Cypress View Foundation		Medicine Hat								X			
Good Samaritan South Ridge Village		Medicine Hat						X		X			
Leisure Way		Medicine Hat								X			
Meadow Lands		Medicine Hat								X			
Medicine Hat Regional Hospital	*	Medicine Hat				X					X		
Riverview Care Centre		Medicine Hat						X					
Sunnyside Care Centre		Medicine Hat						X		X			
The Valleyview		Medicine Hat						X		X			
Milk River Health Centre	*	Milk River				X		X					
Prairie Rose Lodge		Milk River								X			
Big Country Hospital	*	Oyen				X		X					
Piyami Health Care	*	Picture Butte										X	
Piyami Lodge		Picture Butte								X			
Piyami Place		Picture Butte								X			
Good Samaritan Pincher Creek Vista Village		Pincher Creek								X			
Pincher Creek Health Centre	*	Pincher Creek				X		X					
Good Samaritan Prairie Ridge		Raymond								X			
Raymond Health Centre	*	Raymond				X		X					
Clearview Lodge		Taber								X			
Taber Health Centre	*	Taber				X		X					

List of AHS Facilities as of March 31, 2011

Calgary Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Sub-Acute	LTC	Palliative	SL	Cancer	CACC	UCC
Airdrie Health Centre	*	Airdrie											X
Bethany Care Centre Airdrie		Airdrie						X					
Mineral Springs Hospital		Banff				X		X					
Oilfields General Hospital	*	Black Diamond				X		X					
Agape Manor Hospice		Calgary							X				
Alberta Children's Hospital	*	Calgary				X							
Alpha House		Calgary	X										
Approved Homes - Mental Health		Calgary		X									
Aspen Family and Community Network (Eating Disorder Clinic)		Calgary		X									
Aventa Addiction Treatment for Women		Calgary	X										
Bethany Care Centre		Calgary						X					
Bethany Harvest Hills		Calgary						X					
Beverly Centre - Glenmore		Calgary						X					
Beverly Centre - Lake Midnapore		Calgary						X					
Bow Crest Care Centre		Calgary						X					
Bow View Manor		Calgary						X					
Canadian Mental Health Association		Calgary		X									
Canadian Mental Health Association (Hamilton House)		Calgary		X									
Carewest Colonel Belcher Care Centre	*	Calgary						X		X			
Carewest Dr. Vernon Fanning Centre	*	Calgary					X	X					
Carewest Garrison Green	*	Calgary						X					
Carewest George Boyack	*	Calgary						X					
Carewest Glenmore Park	*	Calgary					X						
Carewest Nickle House	*	Calgary								X			
Carewest Royal Park	*	Calgary						X					
Carewest Sarcee	*	Calgary					X	X	X				
Carewest Signal Pointe	*	Calgary						X					
Centre of Hope - Salvation Army		Calgary	X										

List of AHS Facilities as of March 31, 2011

Calgary Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Sub-Acute	LTC	Palliative	SL	Cancer	CACC	UCC
Clifton Manor (Brenda Stafford Foundation)		Calgary						X					
Community Living Alternatives for the Mentally Disabled Association (Community LAMDA)		Calgary		X									
Eau Claire Retirement Residence		Calgary								X			
Edgemont Retirement Residence		Calgary								X			
Extendicare Cedars Villa		Calgary						X					
Extendicare Hillcrest		Calgary						X					
Father Lacombe Care Centre		Calgary						X					
Foothills Medical Centre	•	Calgary				X							
Fresh Start Recovery Centre		Calgary	X										
Glamorgan Care Centre		Calgary						X					
Hospice Calgary - Rosedale Hospice		Calgary							X				
Intercare Brentwood Care Centre		Calgary						X					
Intercare Chinook Care Centre		Calgary						X	X				
Intercare Millrise Care Centre		Calgary						X					
Intercare Southwood Care Centre		Calgary						X	X				
Jackson Willan Seniors' Residence		Calgary								X			
Mayfair Care Centre		Calgary						X					
McKenzie Towne Continuing Care Centre		Calgary						X					
McKenzie Towne Retirement Residence		Calgary								X			
Millrise Place		Calgary								X			
Monterey Place		Calgary								X			
Mount Royal Care Centre		Calgary						X					
Newport Harbour Care Centre		Calgary						X					
Oxford House		Calgary	X										
Personal Care Homes - Continuing Care		Calgary								X			
Peter Lougheed Centre	•	Calgary				X							
Prince of Peace Manor		Calgary								X			
Recovery Acres		Calgary	X										
Renfrew Recovery Centre	•	Calgary	X										

List of AHS Facilities as of March 31, 2011

Calgary Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Sub-Acute	LTC	Palliative	SL	Cancer	CACC	UCC
Richmond Road Diagnostic & Treatment Centre	*	Calgary				OP							
Rockyview General Hospital	*	Calgary				X							
Rotary Flames House	*	Calgary							X				
Scenic Acres Retirement Residence		Calgary								X			
Sheldon M. Chumir Health Centre	*	Calgary											X
South Calgary Health Centre	*	Calgary											X
Southern Alberta Foresenic Psychiatric Centre	*	Calgary			X								
Sunridge Medical Gallery	*	Calgary										X	
Sunrise Native Addiction Services Society		Calgary	X										
Tom Baker Cancer Centre	*	Calgary									X		
Wentworth Manor/The Residence and Court		Calgary						X		X			
Whitehorn Village Retirement Community		Calgary								X			
Wing Kei Care Centre		Calgary						X					
Youth Detoxification and Residential Services	*	Calgary	X										
Youville Women's Residence		Calgary	X										
Canmore General Hospital	*	Canmore				X		X			X		
Little Bow Continuing Care Centre	*	Carmangay						X					
Claresholm Centre for Mental Health and Addictions	*	Claresholm			X								
Claresholm General Hospital	*	Claresholm				X							
Lander Treatment Centre	*	Claresholm	X										
Willow Creek Continuing Care Centre	*	Claresholm						X					
Bethany Care Centre - Cochrane		Cochrane						X					
Cochrane Community Health Centre	*	Cochrane											X
Aspen Ridge Lodge		Didsbury								X			
Didsbury District Health Services	*	Didsbury				X		X					
High River General Hospital	*	High River				X		X			X		
Silver Willow Lodge		Nanton								X			
Foothils Country Hospice		Okotoks							X				

List of AHS Facilities as of March 31, 2011

Calgary Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Sub-Acute	LTC	Palliative	SL	Cancer	CACC	UCC
Okotoks Health and Wellness Centre	*	Okotoks											X
Strathmore District Health Services	*	Strathmore				X		X					
Extendicare Vulcan		Vulcan						X					
Vulcan Community Health Centre	*	Vulcan				X		X					

List of AHS Facilities as of March 31, 2011

Central Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Sub-Acute	LTC	Palliative	SL	Cancer	CACC	UCC
Central Zone	•	Bassano				X		X					
Bashaw Care Centre	•	Bashaw					X	X				X	
Bentley Care Centre	•	Bentley						X				X	
Breton Health Centre	•	Breton						X				X	
Bethany Meadows		Camrose						X		X			
Faith House		Camrose								X			
Louise Jensen Care Centre		Camrose						X					
Memory Lane		Camrose								X			
Rosehaven Care Centre		Camrose						X					
St Mary's Hospital		Camrose				X					X		
Sunrise Village		Camrose								X			
Viewpoint		Camrose								X			
Castor Community Health Centre	•	Castor										X	
Our Lady of the Rosary Hospital		Castor				X		X					
Consort Community Health Centre	•	Consort										X	
Consort Hospital and Care Centre	•	Consort				X		X					
Coronation Community Health Centre	•	Coronation										X	
Coronation Hospital and Care Centre	•	Coronation				X		X		X			
Daysland Health Centre	•	Daysland				X							
Providence Place		Daysland								X			
Drayton Valley Community Health Centre	•	Drayton Valley										X	
Drayton Valley Hospital and Care Centre	•	Drayton Valley				X		X			X		
Serenity House	•	Drayton Valley								X			
Drumheller Health Centre	•	Drumheller				X		X			X		
Grace House		Drumheller	X										
Hillview Lodge		Drumheller								X			
Eckville Community Health Centre	•	Eckville										X	
Eckville Manor House		Eckville								X			
Elnora Community Health Centre	•	Elnora										X	

List of AHS Facilities as of March 31, 2011

Central Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Sub-Acute	LTC	Palliative	SL	Cancer	CACC	UCC
Galahad Care Centre	*	Galahad						X					
Hanna Health Centre	*	Hanna				X		X					
Hardisty Health Centre	*	Hardisty				X		X					
Innisfail Health Centre	*	Innisfail				X		X					
Sunset Manor - Legacy West		Innisfail								X			
Islay Assisted Living	*	Islay								X			
Killam Health Care Centre		Killam				X		X					
Lacombe Community Health Centre	*	Lacombe										X	
Lacombe Hospital and Care Centre	*	Lacombe				X		X					
Manor at Royal Oak Village (Good Samaritan Society)		Lacombe								X			
Lamont Health Care Centre		Lamont				X		X					
Linden Nursing Home		Linden						X					
Points West Living Lloydminster		Lloydminister								X			
Dr Cooke Extended Care Centre		Lloydminster						X					
Slim Thorpe Recovery Centre		Lloydminster	X										
Lloydminster Hospital		Lloydminster, Sask.				X					X		
Mannville Care Centre	*	Mannville						X				X	
Mary Immaculate Health Centre		Mundare										X	
Mary Immaculate Hospital		Mundare						X					
Eagle View Lodge		Myrnam								X			
Enviros Wilderness School (Shunda Creek)		Nordegg	X										
Olds Community Health Centre	*	Olds										X	
Olds Hospital and Care Centre	*	Olds				X		X					
Sunrise Village Olds (Continuum HealthCare Corp)		Olds								X			
Centennial Centre for Mental Health and Brain Injury	*	Ponoka			X								
Northcott Care Centre		Ponoka						X					
Ponoka Community Health Centre	*	Ponoka										X	
Ponoka Hospital and Care Centre	*	Ponoka				X		X					

List of AHS Facilities as of March 31, 2011

Central Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Sub-Acute	LTC	Palliative	SL	Cancer	CACC	UCC
Sunrise Village Ponoka (Continuum HealthCare Corp)		Ponoka								X			
Provost Health Centre	•	Provost				X		X		X			
Addiction Counselling & Prevention Services	•	Red Deer	X										
Bethany CollegeSide (Red Deer)		Red Deer						X					
Extendicare Michener Hill		Red Deer						X		X			
Kentwood Place	•	Red Deer		X									
Pines Lodge - Piper Creek Foundation		Red Deer								X			
Red Deer 49th Street Community Health Centre	•	Red Deer										X	
Red Deer Bremner Avenue Community Health Centre	•	Red Deer										X	
Red Deer Hospice		Red Deer							X				
Red Deer Regional Hospital Centre	•	Red Deer				X					X		
Safe Harbour Society		Red Deer	X										
Symphony Seniors Living at Aspen Ridge		Red Deer								X			
Rimbey Community Health Centre	•	Rimbey										X	
Rimbey Hospital and Care Centre	•	Rimbey				X		X					
Clearwater Centre (Rocky Mountain House)		Rocky Mountain House						X		X			
Rocky Mountain House Health Centre	•	Rocky Mountain House				X							
Stettler Community Health Centre	•	Stettler										X	
Stettler Hospital and Care Centre	•	Stettler				X		X					
Sundre Community Health Centre	•	Sundre										X	
Sundre Hospital and Care Centre	•	Sundre				X		X					
Bethany Sylvan Lake		Sylvan Lake						X		X			
Sylvan Lake Community Health Centre	•	Sylvan Lake										X	
Continuum Healthcare Corp. Three Hills		Three Hills								X			
Three Hills Health Centre	•	Three Hills				X		X					
Tofield Health Centre	•	Tofield				X		X					
St. Mary's Health Care Centre		Trochu						X				X	
Two Hills Health Centre	•	Two Hills				X		X					

List of AHS Facilities as of March 31, 2011

Central Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Sub-Acute	LTC	Palliative	SL	Cancer	CACC	UCC
Century Park Points West Living		Vegreville								X			
Heritage House		Vegreville								X			
St Joseph's General Hospital		Vegreville				X							
St. Michael's Manor Vegreville		Vegreville								X			
Vegreville Care Centre	*	Vegreville						X					
Vermilion Health Centre	*	Vermilion				X		X					
Vermilion Valley Lodge		Vermilion								X			
Viking Extendicare		Viking						X					
Viking Health Centre	*	Viking				X							
Points West Living Wainwright		Wainwright								X			
Wainwright Health Centre	*	Wainwright				X		X					
Good Shepherd Lutheran Home		Wetaskiwin								X			
Peace Hills Lodge		Wetaskiwin								X			
Sunrise Village Wetaskiwin (Continuum HealthCare Corp)		Wetaskiwin								X			
Wetaskiwin Community Health Centre	*	Wetaskiwin										X	
Wetaskiwin Hospital and Care Centre	*	Wetaskiwin				X		X					
Winfield Community Health Centre	*	Winfield										X	

List of AHS Facilities as of March 31, 2011

Edmonton Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Sub-Acute	LTC	Palliative	SL	Cancer	CACC	UCC
Kipohtakawmik Elders Lodge		Alexander Reserve								X			
Place Beausejour		Beaumont								X			
Devon General Hospital	•	Devon				X		X					
Addiction Recovery Centre	•	Edmonton	X										
Alberta Hospital Edmonton	•	Edmonton			X								
All Seniors Care Rutherford		Edmonton								X			
Allen Gray Continuing Care Centre		Edmonton						X					
CapitalCare Dickinsfield	•	Edmonton						X					
CapitalCare Dickinsfield Duplexes (Young Adult Program)	•	Edmonton								X			
CapitalCare Grandview	•	Edmonton					X	X					
CapitalCare Laurier House	•	Edmonton								X			
CapitalCare Lynnwood	•	Edmonton						X					
CapitalCare McConnell Place North	•	Edmonton								X			
CapitalCare McConnell Place West	•	Edmonton								X			
CapitalCare Norwood	•	Edmonton					X	X	X				
Christensen Community - Devonshire Manor		Edmonton								X			
Christensen Community - Garneau Hall		Edmonton								X			
Cross Cancer Institute	•	Edmonton				X					X		
Devonshire Care Centre		Edmonton						X					
Edmonton Chinatown Care Centre		Edmonton						X		X			
Edmonton General Continuing Care Centre		Edmonton					X	X	X				
Edmonton People In Need #4 - Batoma House		Edmonton								X			
Emmanuel Home		Edmonton								X			
Excel Society - Balwin Villa		Edmonton								X			
Excel Society - Grand Manor		Edmonton								X			
Extendicare Holyrood		Edmonton						X					
Extendicare Somerset		Edmonton						X					

List of AHS Facilities as of March 31, 2011

Edmonton Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Sub-Acute	LTC	Palliative	SL	Cancer	CACC	UCC
George Spady Centre Society		Edmonton	X										
Glenrose Rehabilitation Hospital	•	Edmonton				X							
Good Samaritan Dr. Gerald Zetter Care Centre		Edmonton					X	X					
Good Samaritan Millwoods Centre		Edmonton						X					
Good Samaritan Southgate Care Centre		Edmonton						X					
Good Samaritan Wedman House		Edmonton								X			
Grey Nuns Community Hospital		Edmonton				X							
Hardisty Care Centre Ltd.		Edmonton						X					
Health First Strathcona	•	Edmonton											X
Henwood Treatment Centre	•	Edmonton	X										
Innovative Housing - Gravelle		Edmonton								X			
Innovative Housing - Villa Marguerite		Edmonton								X			
Jasper Place Continuing Care Centre		Edmonton						X					
Jellinek House		Edmonton	X										
Jubilee Lodge Nursing Home		Edmonton						X					
Lifestyle Options - Riverbend		Edmonton								X			
Lifestyle Options - Terra Losa		Edmonton								X			
McDougall House		Edmonton	X										
Miller Crossing Care Centre		Edmonton						X					
Misericordia Community Hospital		Edmonton				X							
Northeast Community Health Centre	•	Edmonton				ED							
Our House		Edmonton	X										
Recovery Acres Edmonton		Edmonton	X										
Revera Retirement LP - Churchill Retirement Community		Edmonton								X			
Revera Retirement LP - Riverbend Retirement Residence		Edmonton								X			
Rosedale at Griesbach		Edmonton								X			
Rosedale Estates		Edmonton								X			
Royal Alexandra Hospital	•	Edmonton				X							
Salvation Army Grace Manor		Edmonton								X			

List of AHS Facilities as of March 31, 2011

Edmonton Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Sub-Acute	LTC	Palliative	SL	Cancer	CACC	UCC
Salvation Army Stepping Stone Supportive Residence		Edmonton								X			
Shepherd's Care Foundation - Ashbourne		Edmonton								X			
Shepherd's Care Foundation - Golden Age Manor		Edmonton								X			
Shepherd's Care Foundation - Greenfield		Edmonton								X			
Shepherd's Care Foundation - Millwoods Shepherd's Care Centre		Edmonton						X					
Shepherd's Care Foundation - Shepherd's Garden		Edmonton								X			
Shepherd's Care Foundation, Kensington Village Continuing Care Centre		Edmonton						X		X			
South Terrace Continuing Care Centre		Edmonton						X					
St. Joseph's Auxiliary Hospital		Edmonton						X	X				
St. Michael's Long Term Care Centre		Edmonton					X	X					
St. Thomas Health Centre		Edmonton								X			
Stollery Children's Hospital	*	Edmonton				X							
The Dianne and Irving Kipnes Centre for Veterans	*	Edmonton						X					
The Waterford of Summerlea (Retirement Home)		Edmonton								X			
Touchmark at Wedgewood		Edmonton						X					
University of Alberta Hospital	*	Edmonton				X							
Venta Care Centre		Edmonton						X					
Villa Caritas		Edmonton			X								
Wild Rose Cottage (Chartwell Seniors Housing)		Edmonton								X			
Youth Detoxification and Residential Services	*	Edmonton	X										
Good Samaritan Pembina Village		Evansburg						X					
Fort Saskatchewan Health Centre	*	Fort Saskatchewan				X							
Rivercrest Care Centre		Fort Saskatchewan						X					
Extendicare Leduc		Leduc						X					
Leduc Community Hospital	*	Leduc				X		X					

List of AHS Facilities as of March 31, 2011

Edmonton Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Sub-Acute	LTC	Palliative	SL	Cancer	CACC	UCC
Lifestyle Options - Leduc		Leduc								X			
Salem Manor Nursing Home		Leduc						X					
Aspen House	*	Morinville								X			
Redwater Health Centre	*	Redwater				X		X					
All Seniors Care Summerwood Village		Sherwood Park								X			
Capital Care Strathcona	*	Sherwood Park						X		X			
Country Cottage - Chartwell		Sherwood Park								X			
Sherwood Park Care Centre		Sherwood Park						X					
Good Samaritan Spruce Grove Centre		Spruce Grove								X			
Christensen Community - Citadel Mews West		St. Albert								X			
Citadel Care Centre		St. Albert						X					
Poundmaker's Lodge Treatment Centre		St. Albert	X										
Rosedale St Albert		St. Albert								X			
Sturgeon Community Hospital	*	St. Albert				X							
Youville Auxiliary Hospital (Grey Nuns) of St. Albert		St. Albert						X	X				
Good Samaritan George Hennig Place		Stony Plain								X			
Good Samaritan Stony Plain Care Centre		Stony Plain						X		X			
WestView Health Centre - Stony Plain	*	Stony Plain				X		X					
Family Care Homes		Various								X			
Mental Health Care Homes		Various		X									
Personal Care Homes		Various								X			
West Country Hearth		Villeneuve								X			

List of AHS Facilities as of March 31, 2011

North Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Sub-Acute	LTC	Palliative	SL	Cancer	CACC	UCC
Athabasca Healthcare Centre	*	Athabasca				X		X					
Extendicare Athabasca		Athabasca						X					
Barrhead Healthcare Centre	*	Barrhead				X					X		
Dr. W.R. Keir - Barrhead Continuing Care Centre	*	Barrhead						X					
Mental Health Spaces		Barrhead		X									
Shepherd's Care Barrhead		Barrhead								X			
Beaverlodge Municipal Hospital	*	Beaverlodge				X							
Bonnyville Healthcare Centre		Bonnyville				X		X			X		
Bonnyville Indian Metis Rehabilitation Centre		Bonnyville	X										
Extendicare Bonnyville		Bonnyville						X					
Boyle Healthcare Centre	*	Boyle				X							
Cold Lake Healthcare Centre	*	Cold Lake				X		X					
Ridge Valley Seniors Assistance Society		Crooked Creek								X			
Wabasca/Desmarais Healthcare Centre	*	Desmarais				X							
Edson Healthcare Centre	*	Edson				X		X					
Parkland Lodge		Edson								X			
Elk Point Healthcare Centre	*	Elk Point				X		X					
Fairview Health Complex	*	Fairview				X		X	X				
Northern Lights Regional Health Centre	*	Fort McMurray				X		X			X		
Pastew Place Detox Centre		Fort McMurray	X										
St. Theresa General Hospital	*	Fort Vermilion				X		X					
Fox Creek Healthcare Centre	*	Fox Creek				X							
Glendon Community Health Services	*	Glendon										X	
Grande Cache Community Health Complex	*	Grande Cache				X		X					
Grande Prairie Care Centre		Grande Prairie						X					
NAC Business & Industry Clinic	*	Grande Prairie	X										
Northern Addiction Centre	*	Grande Prairie	X										
Queen Elizabeth II Hospital	*	Grande Prairie				X		X			X		
The Gardens at Emerald Park - Point West Living		Grande Prairie								X			

List of AHS Facilities as of March 31, 2011

North Zone

Facility Name	**Operated by AHS**	**Location**	**Addiction**	**Comm MH**	**Psych**	**Hospital**	**Sub-Acute**	**LTC**	**Palliative**	**SL**	**Cancer**	**CACC**	**UCC**
Youth Detoxification Services	•	Grande Prairie	X										
Grimshaw/Berwyn & District Community Health Centre	•	Grimshaw				ED		X	X				
Action North Recovery Centre		High Level	X										
Northwest Health Centre	•	High Level				X		X					
High Prairie Health Complex	•	High Prairie				X							
J. B. Wood Continuing Care Centre	•	High Prairie						X					
Metis Indian Town Alcohol Association (MITAA Centre)		High Prairie	X										
Hinton Healthcare Centre	•	Hinton				X					X		
Mountain View Centre		Hinton								X			
Hythe Continuing Care Centre	•	Hythe						X					
Evergreen Alpine - Jasper		Jasper								X			
Seton - Jasper Healthcare Centre	•	Jasper				X							
Heimstaed Lodge		La Crete								X			
La Crete Continuing Care Centre	•	La Crete						X	X				
La Crete Health Centre	•	La Crete											X
William J. Cadzow - Lac La Biche Healthcare Centre	•	Lac La Biche				X		X					
Manning Community Health Centre	•	Manning				X		X					
Extendicare Mayerthorpe		Mayerthorpe						X					
Mayerthorpe Healthcare Centre	•	Mayerthorpe				X		X					
Manoir du Lac		McLennan						X		X			
Sacred Heart Community Health Centre	•	McLennan				X							
Chateau Lac St. Anne		Onoway								X			
Onoway Community Health Services	•	Onoway										X	
Peace River Community Health Centre	•	Peace River				X		X			X		
Radway Continuing Care Centre	•	Radway						X					
Rainbow Lake Health Centre	•	Rainbow Lake										X	
Slave Lake Healthcare Centre	•	Slave Lake				X		X					
George McDougall - Smoky Lake Healthcare Centre	•	Smoky Lake				X		X					
Smoky Lake Continuing Care Centre	•	Smoky Lake						X					

List of AHS Facilities as of March 31, 2011

North Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital	Sub-Acute	LTC	Palliative	SL	Cancer	CACC	UCC
Central Peace Health Complex	•	Spirit River				X		X					
Extendicare St. Paul		St Paul						X					
St. Therese - St. Paul Healthcare Centre	•	St Paul				X		X					
St. Paul Abilities Network		St. Paul		X									
Swan Hills Healthcare Centre	•	Swan Hills				X							
Thorhild Community Health Services	•	Thorhild										X	
Valleyview Health Centre	•	Valleyview				X		X					
Our Lady's Community Health Services	•	Vilna										X	
Vilna Villa		Vilna								X			
Smithfield Lodge		Westlock								X			
Westlock Healthcare Centre	•	Westlock				X		X					
Spruceview Lodge		Whitecourt								X			
Whitecourt Healthcare Centre	•	Whitecourt				X							

AHS Q4 Performance Report

Alberta Health
Services

Alberta Health Services

Q4 Performance Report

June 2011

Prepared by

Data Integration, Measurement and Reporting

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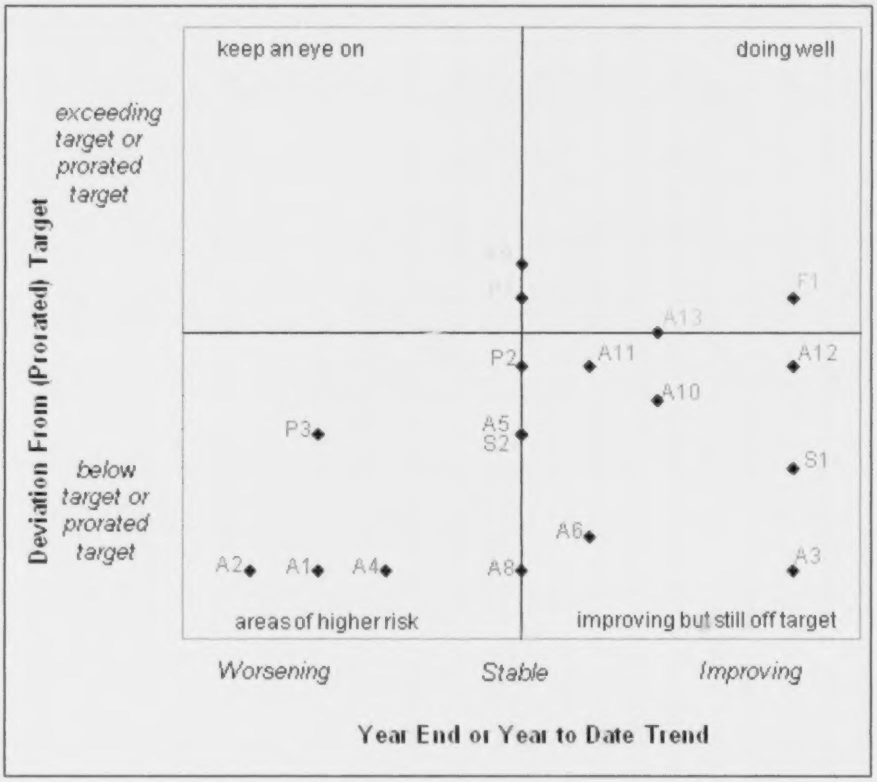
Executive Summary

Of the sixty indicators listed on the AHS Performance Report, Q4 2010/11, overall status can be summarized as follows:

- 16 red lights (27 per cent)
- 12 yellow lights (20 per cent)[1]
- 8 green lights (13 per cent)
- 14 indicators with no available status (targets not defined) (23 per cent)
- 10 indicators in development (17 per cent)

For those 18 updated **quarterly** indicators where performance targets and trend information are both available, the recommended "action status" for AHS can be summarized using the following representation:



Legend

A. Improving Access, Reducing Wait Times
S. Choice and Quality for Seniors
P. Building a Primary Care Foundation
F. Enabling Our People / Enabling One Health System

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[1] Registered Nurse Graduates Hired by AHS (%) counted in Yellow status category. This measure appears with both green (for all hires) and red (for non-casual hires) status flags in Dashboard.

Performance is of most concern for those indicators falling into the bottom-left quadrant; i.e. where current performance is outside acceptable range as expected if progressing towards the defined 2010/11 target (i.e. the yellow or red lights) and the trend over time is getting worse. Indicators in this category continue to be at high risk and are organizational priorities for improvement. These include:

A1. CABG Wait Time for Urgent Category (Urgency Level I)
A2. CABG Wait Time for Semi-Urgent Category (Urgency II)
A4. Hip Replacement Surgery Wait Time (90th percentile in weeks)
A5. Knee Replacement Surgery Wait Time (90th percentile in weeks)
A6. Cataract Surgery Wait Time (Weeks)
A8. Radiation Therapy Wait Time - Referral to consultation (weeks)
S2. People Waiting in Community for Continuing Care Placement
P2. Family Practice Sensitive Conditions (% of ED visits)
P3. Health Link Alberta Service Level (% answered within 2 minutes)

Indicators falling into the bottom-right quadrant are those whose performance also remains outside acceptable range relative to the expected quarterly progression to achieve the outlined 2010/11 target (red and yellow lights), yet which show an improving trend over time. Actions may already be underway to improve performance, or will need to be determined; however, at present these are seen to be improving but still off target:

A3. CABG Wait Time for Scheduled Category (Urgency III)
A10. Discharged ED Length of Stay (% within 4 hours) (16 Higher Volume EDs)
A11. Patients Discharged from Emergency Dept or Urgent Care Centre within 4 hours (%) All Sites
A12. Patients Admitted from Emergency Dept within 8 hours (%) 15 Higher Volume EDs
S1. People Waiting in Acute/Sub-Acute Beds for Continuing Care Placement

Indicators falling into the top-left quadrant are those whose performance is at or better than the prorated quarterly 2010/11 target (green lights), yet which show a worsening or stable trend over time. While not identified as concern by this quarter status determination, a shift towards an improving trend may be required to meet end of year targets. These represent areas for the organization to keep an eye on

A9. Radiation Therapy Wait Time - Ready-to-Treat to First Radiation Therapy
P1. Admissions for Ambulatory Care Sensitive Conditions (rate per 100,000)

Indicators falling into the top-right quadrant are those whose performance is at or better than the prorated 2010/11 target (green lights) or within an acceptable range (yellow lights), and which show an improving trend over time. Again, no actions are recommended, as these represent areas where the organization is doing well:

A13. Patients Admitted from Emergency Dept within 8 hours (%) All Sites
F1. Number of Netcare Users

Introduction

Alberta Health Services is on a journey to become the best publicly-funded health-care system in Canada.

The start of this journey begins with knowledge and ambition: knowledge of how our services compare to the best, and ambition to improve the quality of our services and the health of Albertans.

In this report we are examining both. We are measuring our performance near the start of this journey, and we are measuring our progress towards the targets, which Alberta Health Services (AHS) established in partnership with Alberta Health and Wellness, and through consultation with clinical leaders and a review of national benchmarks.

The targets are intentionally ambitious. Setting goals for performance and monitoring our progress in reaching these goals are fundamental to transforming the health-care system.

The report also links performance targets to our five Transformational Improvement Programs to help us ensure we are making the right improvements and are putting our resources in the right places.

Reporting our performance: January 1 – March 31, 2011

Designed to gauge performance and drive improvement, this report provides a snapshot in time and shows us where we are performing well and areas where we need to take action to improve.

A few areas where AHS has met or is on track to meeting the annual target include: patients admitted from ED within 8 hours (all sites), patient satisfaction rates in hospitals, access to radiation therapy (ready-to-treat status until first treatment), admissions for ambulatory care sensitive conditions, and number of Netcare users. In addition, while not meeting the 2010/11 performance targets, AHS has made significant improvement on the number of people waiting in acute/sub-acute beds for continuing care placement, as well as the percentage of Albertans enrolled in a Primary Care Network.

We are also responding to a number of priority areas with immediate and aggressive actions to improve performance. These areas include: emergency department lengths of stay, access to continuing care beds, as well as wait times for hip replacements, knee replacements, coronary artery bypass graft surgeries, and cataract surgeries.

Highlights of actions underway to improve performance in these priority areas:

- Ongoing implementation of new Emergency Department (ED) surge capacity protocols to provide additional capacity when demands on Emergency and across the health system reach critical thresholds. When reached, the new protocols trigger immediate action to reduce wait times.
- Completing the addition of 360 new hospital beds by June 30, 2011 (323 beds were opened as of March 31, 2011). As well, an additional 40 hospital beds will be opened by March, 2012. More open hospital beds will reduce ED length of stay for many patients requiring admission.
- Informing Albertans about their care options. Many Albertans visit the ED for illness and injuries that could be treated by a family doctor, at a drop-in clinic or an urgent care centre.

- Adding 1,000 new continuing care beds in 2011/12, on top of the 1,166 beds added during the 2010/11 year. This additional capacity allows us to free up hospital beds currently occupied by Albertans whose health needs would be better met outside of the hospital. More open hospital beds will help improve ED length of stay for many patients requiring admission.
- Increasing home care spending in an effort to keep seniors safe, healthy and independent in their homes and reduce the number of avoidable ED visits.
- Implementing care pathways for patients requiring hip or knee replacement. This involves a central intake of referrals and offering a "next available surgeon and site" option to interested patients. The project is now underway in all 12 facilities performing hip and knee replacements.
- Increasing cataract surgeries: funding allocation to maintain increased volumes of cataract procedures in 2011/12 in order to reduce wait times.

In addition to these high priority areas, there are others that also require more attention and action. These are highlighted in the report and information on actions being taken can be found in the summary page for each measure.

In order to transform the way we deliver health services across the province, we need a vision for the future, transparent and accountable action plans, reliable measures, and specific targets. We need to know how well we are doing and where we need to improve. And, as we make improvements, we need an ongoing process to measure effectiveness.

More than just numbers, this report is a dynamic road map for the future and an essential tool to reach our goal of becoming the best publicly-funded health-care system in Canada.

With the release of each quarterly report, AHS reaffirms our commitment to provide timely and relevant information to the public. While the figures presented here measure our progress to date, the most important measure of our success in the future will be the health and satisfaction levels of Albertans.

For more information on actions we are taking and the programs we have in place to transform our health system, I encourage you to visit our website at www.albertahealthservices.ca.

Dr. Chris Eagle, President & Chief Executive Officer, Alberta Health Services

What's being measured?

Alberta Health Services (AHS) delivers health services in five zones, each with different populations and geography. The measures presented here track our current and projected performance in a broad range of indicators that span the continuum of care. They include primary care, continuing care, population and public health, and acute (hospital-based) care. In addition, they touch upon various dimensions of quality such as timeliness, effectiveness, efficiency, satisfaction rates and others.

How to read this report

This report is aligned with both the 2010-2015 Health Plan and Becoming the Best: Alberta's 5-Year Health Action Plan, as well as other AHS reports such as the Quality and Patient Safety Dashboard and the Human Resources Dashboard.

Information is at your fingertips in the "dashboard" which provides an at-a-glance view of all performance measures and allows you to see trends over time. The point-and-click drill-down features help you better understand the meaning of the data provided, and allows access to more detailed information by zone or site (as appropriate to the specific indicator).

You'll also have access to detailed definitions and one-page descriptions of each of indicator with comments on existing performance, actions being taken by AHS to improve performance, and other information.

The performance dashboard uses a "traffic light" method to show how AHS is performing relative to 2010-11 targets. Each indicator where quarterly updates are available has been compared to a prorated quarterly target as opposed to the year-end target. The prorated target simply allows us to see where we are this quarter relative to where we would expect to be. This "staggering" of targets throughout the year allows us to determine whether we are achieving the level of performance at the rate we expected.

A "green light" is used when actual performance is at or better than the prorated target; a "yellow light" represents performance within an acceptable range of the target (we are at least within 75 per cent of where we were expected to be), and a "red light" shows where performance is beyond an acceptable range. A green or yellow light can also be changed to red if the trends indicate there is risk of achieving our performance goals for the end of the year.

For indicators measured annually rather than quarterly, they are evaluated against the year-end target, where performance within 10 per cent is considered an acceptable range, resulting in a "yellow light."

Data availability for quarterly updates varies due to data source differences. Most of the quarterly performance measures in this report are updated to the fourth quarter (January-March, 2011). For those indicators reporting Quarter 3 data, the following table explains why there is a one quarter reporting lag in each case.

Quarterly Measures with a One Quarter Reporting Lag	Data Timeline Clarification
• Patient Satisfaction - Acute Care	For this survey, patients are called up to six weeks after they leave the hospital. Data are then prepared and analyzed for reporting. This means patient experience information for a particular quarter is available approximately 2 months after the end of a reporting period.

Data included in this report come from Alberta Health Services, Alberta Health and Wellness, Health Quality Council of Alberta, and Statistics Canada.

AHS Performance Dashboard

Status

□ Performance is at or better than target, continue to monitor
△ Performance is within acceptable range of target, monitor and take action as appropriate
● Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	Actual Performance	Year to Date Target	Status	Trend	Annual Target
Staying Healthy / Improving Population Health						
◇Life Expectancy	2010	81.6	na	na		na
◇Potential Years of Life Lost (per 1,000 Population)	2010	44.8	na	na		na
Colorectal Cancer Screening Participation Rate	2008	35.5%	na	△†	na*	37%† 2010
Breast Cancer Screening Participation Rate	2008 - 2009	55.9%	na	△†	na*	57%† 2009-2010
Cervical Cancer Screening Participation Rate	Jan 07- Dec 09	70.7%	na	△†	na*	72%† 2008-10
Building a Primary Care Foundation						
◇Seniors (65+) Influenza Immunization Rate	2010/11	59%	na	●		75%
◇Children (6 to 23 Months) Influenza Immunization Rate	2010/11	27%✓	na	●		75%^
◇Childhood Immunization Rates for DTaP	2008	83.8%	na	●		95%
◇Childhood Immunization Rates for MMR	2008	89.3%✓	na	△		95%
Albertans Enrolled in a Primary Care Network (%)	Apr 2011	72%✓	na	△		75%
◇Admissions for Ambulatory Care Sensitive Conditions (rate per 100,000 Population)	Q4 2010/11	74✓	76 (quarterly)	□		304 (annually)
◇Family Practice Sensitive Conditions (% of ED visits)	Q4 2010/11	28.0% ✓	27.3%	△		27%
Health Link Wait Time (% answered within 2 minutes)	Q4 2010/11	71.7% ✓	80%	●		80%
◇Children Receiving Community Mental Health Treatment within 30 Days (%)	Q4 2010/11	79%✓	85%	△		85%

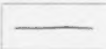
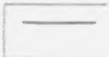
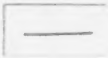
◇Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.
† Interim target pending confirmation. Status based on interim target.
* Trend for these measures cannot be determined until subsequent data is available.
^ Target under review.
✓Indicates data points that have been updated since the previous report.

Alberta Health Services

AHS Performance Dashboard (continued)

Status

■	Performance is at or better than target, continue to monitor
△	Performance is within acceptable range of target, monitor and take action as appropriate
●	Performance is outside acceptable range of target, take action and monitor progress

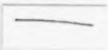
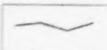
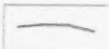
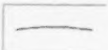
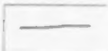
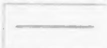
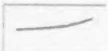
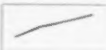
Performance Measure	Reporting Period	Actual Performance	Year to Date Target	Status	Trend	Annual Target
Improving Access, Reducing Wait Times						
◇ Urgent CABG Wait Time (90th percentile in weeks)	Q4 2010/11	2.2✓	1.5	●		1.5
◇ Semi-urgent CABG Wait Time (90th percentile in weeks)	Q4 2010/11	9.6 ✓	5.0	●		5.0
◇ Scheduled CABG Wait Time (90th percentile in weeks)	Q4 2010/11	19.9 ✓	15	●		15.0
◇Hip Replacement Surgery Wait Time (90th percentile in weeks)	Q4 2010/11	36.6 ✓	28.0	●		28
◇Knee Replacement Surgery Wait Time (90th percentile in weeks)	Q4 2010/11	48.0 ✓	42.0	●		42
◇Cataract Surgery Wait Time (90th percentile in weeks)	Q4 2010/11	46.1✓	36.0	●		36
◇Other Scheduled Surgery Wait Time (90th percentile in weeks)	Q4 2010/11	26.3 ✓	tbd	na		tbd
◇Radiation Therapy Access (referral to 1st consult) (90th percentile in weeks)	Q4 2010/11	5.5 ✓	4.0	●		4
◇Radiation Therapy Access (ready to treat to first therapy) (90th percentile in weeks)	Q4 2010/11	3.7 ✓	4.0	■		4
◇Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume EDs) £	Q4 2010/11	65% ✓	70%	△		70%
◇Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	Q4 2010/11	78% ✓	82%	△		82%
◇Patients Admitted from ED within 8 hours (%) (15 Higher Volume EDs) £	Q4 2010/11	44% ✓	45%	△		45%
◇Patients Admitted from ED within 8 hours (%) (All Sites) £	Q4 2010/11	55% ✓	55%	■		55%

◇Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.
* Trend for these measures cannot be determined until subsequent data is available.
✓Indicates data points that have been updated since the previous report.
£The Weekly ED Length of Stay (LOS) being published separate from this report are based upon a subset of the sites identified in the current ED LOS data definitions where more timely data is readily available. There is currently a three month time lag in obtaining information from alternate data sources that allow for a more complete provincial picture. AHS is currently working on integrating the data to support these measures using more timely data sources. Data are accurate to ±2%.
∞ Number of Home Care Clients – Q2 2010/11 data estimated for North Zone.

AHS Performance Dashboard (continued)

Status

□	Performance is at or better than target, continue to monitor
△	Performance is within acceptable range of target, monitor and take action as appropriate
●	Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	Actual Performance	Year to Date Target	Status	Trend	Annual Target
Choice and Quality for Seniors						
◇People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	Q4 2010/11	471 ✓	400	△		400
◇People Waiting in Community for Continuing Care Placement	Q4 2010/11	1,110 ✓	975	●		975
◇Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	Q4 2010/11	47✓	tbd	na		tbd
◇Number of Home Care Clients	Q4 2010/11	56,041✓	na	na	na*	tbd
◇Rating of Care Nursing Home Family	2008	8.1	na	na	na	tbd
◇Rating of Care Nursing Home Resident	2008	8.1	na	na	na	tbd
Enabling Our People / Enabling One Health System						
◇Headcount to FTE Ratio	Q4 2010/11	1.57 ✓	na	□		1.63
◇Registered Nurse Graduates Hired by AHS (%)	Q4 2010/11	Total: 87% ✓ Non-Casual: 41% ✓	70%	Total □ Non-Casual ●	na	70% by year end
◇Disabling Injury Rate	2010	3.19	na	●	na	2.41
◇Staff Overall Engagement (%)	2009/10	35%	na	●	na*	43%
◇Physician Overall Engagement (%)	2009/10	26%	na	●	na*	43%
Full-time to Part-time Clinical Worker Ratio	Q4 2010/11	0.98✓	na	na		tbd
Employee Absenteeism Rate	Q4 2010/11	12✓ days/FTE (annualized)	na	na		tbd
Overtime Hours to Paid Hours Ratio	Q4 2010/11	2.17%✓	na	na		tbd
◇Number of Netcare Users	Q4 2010/11	11,816 ✓	11,575	□		11,575
◇On Budget: Year to Date	2010/11	$116M ✓	$0	□	na	$0

◇Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.
✓Indicates data points that have been updated since the previous report.

AHS Performance Dashboard (continued)

Status

☐	Performance is at or better than target, continue to monitor
△	Performance is within acceptable range of target, monitor and take action as appropriate
●	Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	Actual Performance	Year to Date Target	Status	Trend	Annual Target
Quality and Patient Safety						
◇Patient Satisfaction - Acute Care	Q3 2010/11	82.2%	na	☐	na*	80%
◇Patient Satisfaction - Addictions and Mental Health (AHS)	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q1 2011/12					
Percentage of Patient Feedback as Commendations	Q4 2010/11	9.12%	na	na	na	tbd
Percentage of Patient Concerns Escalated to Patient Concerns Officer	Q4 2010/11	0.29%	na	na	na	tbd
◇ Albertans Reporting Unexpected Harm	2010	9%	na	☐		9%
◇ Patient Satisfaction Emergency Department	2010	59%	na	na	na	tbd
◇ Patient Satisfaction Health Care Services Personally Received	2010	62% ✓	na	△		65%
◇ Patient Satisfaction Mental Health Services in Alberta	2010	78% ✓	na	na	na	tbd
Central Venous Catheter Bloodstream Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q1 2011/12					
◇Hospital Acquired MRSA Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2011/12					
◇Surgical Site Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2012/13					
C-Difficile Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q3 2011/2012					
Time to Resolve Patient Concerns	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q3 2011/2012					
Never (Adverse) Events	Measurement proposed and being evaluated, no reporting strategy or start time available.					
Percent of patients diagnosed with diabetes with controlled blood sugar (haemoglobin A1c<8)	Measurement proposed and being evaluated; no reporting strategy or start time available.					
Percent of patients diagnosed with hypertension with blood pressure control	Measurement proposed and being evaluated; no reporting strategy or start time available.					
Number of continuing care facility residents transferred to acute care for fall-related injury	Measurement proposed and being evaluated; no reporting strategy or start time available.					

◇Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.
✓Indicates data points that have been updated since the previous report.

Alberta Health Services

South Zone Performance Dashboard

Status

□	Performance is at or better than target, continue to monitor
△	Performance is within acceptable range of target, monitor and take action as appropriate
●	Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target¥
Staying Healthy / Improving Population Health						
◇Life Expectancy	2010	81.6	**80.3**	na	na	**na**
◇Potential Years of Life Lost (per 1,000 Population)	2010	44.8	**49.6**	na	na	**na**
Breast Cancer Screening Participation Rate	2008 - 2009	55.9%	**57.2%**	na	□†	**57%†** **2009-2010**
Cervical Cancer Screening Participation Rate	Jan 2007 - Dec 2009	70.7%	**65.1%**	na	△†	**72%†** **2008-2010**
Building a Primary Care Foundation						
◇Seniors (65+) Influenza Immunization Rate	2010/11	59%	**59%**	na	●	**75%**
◇Children (6 to 23 Months) Influenza Immunization Rate	2010/11	27%	**21%**	na	●	**75%^**
◇Childhood Immunization Rates for DTaP	2008	83.8%	**83.60%**	na	●	**95%**
◇Childhood Immunization Rates for MMR	2008	89.3%	**88.30%**	na	△	**95%**
Albertans Enrolled in a Primary Care Network (%)	Apr 2011	72%	**74%**	na	△	**75%**
◇Admissions for Ambulatory Care Sensitive Conditions (rate per 100,000 Population)	Q4 2010/11	74	**102**	**76**	●	304 (annually)
◇Family Practice Sensitive Conditions (% of ED visits)	Q4 2010/11	28.0%	**30.2%**	**27%**	●	27%
◇Children Receiving Community Mental Health Treatment within 30 Days (%)	Q4 2010/11	79%	**91%**	**82.8%**	□	85%
Improving Access, Reducing Wait Times						
◇Hip Replacement Surgery Wait Time (90th percentile in weeks)	Q4 2010/11	36.6	**42.3**	**28**	●	28
◇Knee Replacement Surgery Wait Time (90th percentile in weeks)	Q4 2010/11	48.0	**63.8**	**42**	●	42

¥Annual Targets as per Performance Agreements.
◇Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.
† Interim target pending confirmation. Status based on interim target.
* Trend for these measures cannot be determined until subsequent data is available.
^ Target under review.

South Zone Performance Dashboard (continued)

Status

□	Performance is at or better than target, continue to monitor
△	Performance is within acceptable range of target, monitor and take action as appropriate
●	Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target¥
◇Cataract Surgery Wait Time (90th percentile in weeks)	Q4 2010/11	46.1	41.1	**36**	●	36
◇Other Scheduled Surgery Wait Time (90th percentile in weeks)	Q4 2010/11	26.3	23.3	**tbd**	na	tbd
◇Radiation Therapy Access (referral to 1st consult) (90th percentile in weeks)	Q4 2010/11	5.5	**4.9**	**4**	●	4
◇Radiation Therapy Access (ready to treat to first therapy) (90th percentile in weeks)	Q4 2010/11	3.7	**1.6**	**4**	□	4
◇Patients Discharged from ED or UCC within 4 hours (%) (Higher Volume EDs) £	Q4 2010/11	65%	**82%**	**70%**	□	70%
◇Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	Q4 2010/11	78%	**88%**	**82%**	□	82%
◇Patients Admitted from ED within 8 hours (%) (Higher Volume EDs) £	Q4 2010/11	44%	**88%**	**45%**	□	45%
◇Patients Admitted from ED within 8 hours (%) (All Sites) £	Q4 2010/11	55%	**88%**	**55%**	□	55%
Choice and Quality for Seniors						
◇People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	Q4 2010/11	471	**22**	**25**	□	25
◇People Waiting in Community for Continuing Care Placement	Q4 2010/11	1,110	**67**	**56**	●	56
◇Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	Q4 2010/11	47	**16**	**tbd**	na	tbd
◇Number of Home Care Clients	Q4 2010/11	56,041	**5,587**	**tbd**	na	tbd
Enabling Our People / Enabling One Health System						
◇Staff Overall Engagement (%)	2009/10	35%	**35%**	na	●	**43%**
◇Physician Overall Engagement (%)	2009/10	26%	**20%**	na	●	**43%**
◇Number of Netcare Users	Q4 2010/11	11,816	**na**	**na**	na	na

¥Annual Targets as per Performance Agreements.

◇Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.

* Trend for these measures cannot be determined until subsequent data is available.

£The Weekly ED Length of Stay (LOS) being published separate from this report are based upon a subset of the sites identified in the current ED LOS data definitions where more timely data is readily available. There is currently a three month time lag in obtaining information from alternate data sources that allow for a more complete provincial picture. AHS is currently working on integrating the data to support these measures using more timely data sources. Data are accurate to ±2%.

∞ Number of Home Care Clients – Q2 2010/11 data estimated for North Zone.

Alberta Health Services

South Zone Performance Dashboard (continued)

Status

■	Performance is at or better than target, continue to monitor
△	Performance is within acceptable range of target, monitor and take action as appropriate
●	Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target¥
Quality and Patient Safety						
◇Patient Satisfaction - Addictions and Mental Health (AHS)	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q1 2011/12					
Percentage of Patient Feedback as Commendations	Q4 2010/11	9.12%	**7.01%**	**na**	na	tbd
Percentage of Patient Concerns Escalated to Patient Concerns Officer	Q4 2010/11	0.29%	**0%**	**na**	na	tbd
◇ Albertans Reporting Unexpected Harm	2010	9%	**8%**	na	■	**9%**
◇ Patient Satisfaction Emergency Department	2010	59%	**59%**	na	na	**tbd**
◇ Patient Satisfaction Health Care Services Personally Received	2010	62%	**66%**	na	■	**65%**
◇ Patient Satisfaction Mental Health Services in Alberta	2010	78%	**78%**	na	na	**tbd**
Central Venous Catheter Bloodstream Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q1 2011/12					
◇Hospital Acquired MRSA Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2011/12					
◇Surgical Site Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2012/13					
C-Difficile Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q3 2011/2012					
Time to Resolve Patient Concerns	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q3 2011/2012					
Never (Adverse) Events	Measurement proposed and being evaluated, no reporting strategy or start time available.					
Percent of patients diagnosed with diabetes with controlled blood sugar (haemoglobin A1c<8)	Measurement proposed and being evaluated, no reporting strategy or start time available.					
Percent of patients diagnosed with hypertension with blood pressure control	Measurement proposed and being evaluated, no reporting strategy or start time available.					
Number of continuing care facility residents transferred to acute care for fall-related injury	Measurement proposed and being evaluated, no reporting strategy or start time available.					

¥Annual Targets as per Performance Agreements.

◇Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.

Alberta Health Services

Calgary Zone Performance Dashboard

Status

□ Performance is at or better than target, continue to monitor

△ Performance is within acceptable range of target, monitor and take action as appropriate

● Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target¥
Staying Healthy / Improving Population Health						
◇Life Expectancy	2010	81.6	**82.9**	na	na	**na**
◇Potential Years of Life Lost (per 1,000 Population)	2010	44.8	**37**	na	na	**na**
Breast Cancer Screening Participation Rate	2008 - 2009	55.9%	**51.9%**	na	△†	**57%†** **2009-2010**
Cervical Cancer Screening Participation Rate	Jan 2007-Dec 2009	70.7%	**74.8%**	na	□†	**72%†** **2008-2010**
Building a Primary Care Foundation						
◇Seniors (65+) Influenza Immunization Rate	2010/11	59%	**62%**	na	●	**75%**
◇Children (6 to 23 Months) Influenza Immunization Rate	2010/11	27%	**39%**	na	●	**75%^**
◇Childhood Immunization Rates for DTaP	2008	83.8%	**86.2%**	na	△	**95%**
◇Childhood Immunization Rates for MMR	2008	89.3%	**87.8%**	na	△	**95%**
Albertans Enrolled in a Primary Care Network (%)	Apr 2011	72%	**77%**	na	□	**75%**
◇Admissions for Ambulatory Care Sensitive Conditions (rate per 100,000 Population)	Q4 2010/11	74	**56**	**76**	□	304 (annually)
◇Family Practice Sensitive Conditions (% of ED visits)	Q4 2010/11	28.0%	**22.1%**	**27.3%**	□	27%
◇Children Receiving Community Mental Health Treatment within 30 Days (%)	Q4 2010/11	79%	**80%**	**82.8%**	△	85%
Improving Access, Reducing Wait Times						
◇ Urgent CABG Wait Time (90th percentile in weeks)	Q4 2010/11	2.2	**1.8**	**1.5**	●	1.5
◇ Semi-urgent CABG Wait Time (90th percentile in weeks)	Q4 2010/11	9.6	**6.1**	**5.0**	●	5.0
◇ Scheduled CABG Wait Time (90th percentile in weeks)	Q4 2010/11	19.9	**24.7**	**15.0**	●	15.0

¥Annual Targets as per Performance Agreements.

◇Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.

† Interim target pending confirmation. Status based on interim target.

* Trend for these measures cannot be determined until subsequent data is available.

^ Target under review.

Calgary Zone Performance Dashboard (continued)

Status

□ Performance is at or better than target, continue to monitor

△ Performance is within acceptable range of target, monitor and take action as appropriate

● Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target¥
◇Hip Replacement Surgery Wait Time (90th percentile in weeks)	Q4 2010/11	36.6	**29.8**	**28**	△	28
◇Knee Replacement Surgery Wait Time (90th percentile in weeks)	Q4 2010/11	48.0	**33.3**	**42**	□	42
◇Cataract Surgery Wait Time (90th percentile in weeks)	Q4 2010/11	46.1	**56.9**	**36**	●	36
◇Other Scheduled Surgery Wait Time (90th percentile in weeks)	Q4 2010/11	26.3	**27.7**	**tbd**	na	tbd
◇Radiation Therapy Access (referral to 1st consult) (90th percentile in weeks)	Q4 2010/11	5.5	**6**	**4**	●	4
◇Radiation Therapy Access (ready to treat to first therapy) (90th percentile in weeks)	Q4 2010/11	3.7	**3.7**	**4**	□	4
◇Patients Discharged from ED or UCC within 4 hours (%) (Higher Volume EDs) £	Q4 2010/11	65%	**61%**	**70%**	●	70%
◇Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	Q4 2010/11	78%	**70%**	**82%**	●	82%
◇Patients Admitted from ED within 8 hours (%) (Higher Volume EDs) £	Q4 2010/11	44%	**42%**	**45%**	△	45%
◇Patients Admitted from ED within 8 hours (%) (All Sites) £	Q4 2010/11	55%	**43%**	**55%**	●	55%
Choice and Quality for Seniors						
◇People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	Q4 2010/11	471	**146**	**155**	□	155
◇People Waiting in Community for Continuing Care Placement	Q4 2010/11	1,110	**504**	**437**	●	437
◇Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	Q4 2010/11	47	**47**	**tbd**	na	tbd
◇Number of Home Care Clients	Q4 2010/11	56,041	**14,252**	**tbd**	na	tbd
Enabling Our People / Enabling One Health System						
◇Staff Overall Engagement (%)	2009/10	35%	**33%**	na	●	**43%**
◇Physician Overall Engagement (%)	2009/10	26%	**27%**	na	●	**43%**
◇Number of Netcare Users	Q4 2010/11	11,816	**na**	**na**	na	na

¥Annual Targets as per Performance Agreements.

◇Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.

* Trend for these measures cannot be determined until subsequent data is available.

£The Weekly ED Length of Stay (LOS) being published separate from this report are based upon a subset of the sites identified in the current ED LOS data definitions where more timely data is readily available. There is currently a three month time lag in obtaining information from alternate data sources that allow for a more complete provincial picture. AHS is currently working on integrating the data to support these measures using more timely data sources. Data are accurate to ±2%.

∞ Number of Home Care Clients – Q2 2010/11 data estimated for North Zone.

Calgary Zone Performance Dashboard (continued)

Status

☐ Performance is at or better than target, continue to monitor

△ Performance is within acceptable range of target, monitor and take action as appropriate

● Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target¥
Quality and Patient Safety						
◇Patient Satisfaction - Addictions and Mental Health (AHS)	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q1 2011/12					
Percentage of Patient Feedback as Commendations	Q4 2010/11	9.12%	**10.57%**	**na**	na	tbd
Percentage of Patient Concerns Escalated to Patient Concerns Officer	Q4 2010/11	0.29%	**0.60%**	**na**	na	tbd
◇ Albertans Reporting Unexpected Harm	2010	9%	**10%**	na	△	**9%**
◇ Patient Satisfaction Emergency Department	2010	59%	**61%**	na	na	**tbd**
◇ Patient Satisfaction Health Care Services Personally Received	2010	62%	**60%**	na	△	**65%**
◇ Patient Satisfaction Mental Health Services in Alberta	2010	78%	**78%**	na	na	**tbd**
Central Venous Catheter Bloodstream Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q1 2011/12					
◇Hospital Acquired MRSA Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2011/12					
◇Surgical Site Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2012/13					
C-Difficile Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q3 2011/2012					
Time to Resolve Patient Concerns	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q3 2011/2012.					
Never (Adverse) Events	Measurement proposed and being evaluated; no reporting strategy or start time available.					
Percent of patients diagnosed with diabetes with controlled blood sugar (haemoglobin A1c<8)	Measurement proposed and being evaluated; no reporting strategy or start time available.					
Percent of patients diagnosed with hypertension with blood pressure control	Measurement proposed and being evaluated; no reporting strategy or start time available.					
Number of continuing care facility residents transferred to acute care for fall-related injury	Measurement proposed and being evaluated; no reporting strategy or start time available.					

¥Annual Targets as per Performance Agreements.

◇Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.

Central Zone Performance Dashboard

Status

■	Performance is at or better than target, continue to monitor
△	Performance is within acceptable range of target, monitor and take action as appropriate
●	Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target[¥]
Staying Healthy / Improving Population Health						
◇Life Expectancy	2010	81.6	**80.7**	na	na	**na**
◇Potential Years of Life Lost (per 1,000 Population)	2010	44.8	**51.4**	na	na	**na**
Breast Cancer Screening Participation Rate	2008 - 2009	55.9%	**54.1%**	na	△[†]	**57%[†]** **2009-2010**
Cervical Cancer Screening Participation Rate	Jan 2007 - Dec 2009	70.7%	**64.8%**	na	△[†]	**72%[†]** **2008-2010**
Building a Primary Care Foundation						
◇Seniors (65+) Influenza Immunization Rate	2010/11	59%	**54%**	na	●	**75%**
◇Children (6 to 23 Months) Influenza Immunization Rate	2010/11	27%	**22%**	na	●	**75%[^]**
◇Childhood Immunization Rates for DTaP	2008	83.8%	**75.1%**	na	●	**95%**
◇Childhood Immunization Rates for MMR	2008	89.3%	**86.82%**	na	△	**95%**
Albertans Enrolled in a Primary Care Network (%)	Apr 2011	72%	**66%**	na	●	**75%**
◇Admissions for Ambulatory Care Sensitive Conditions (rate per 100,000 Population)	Q4 2010/11	74	**96**	**76**	●	304 (annually)
◇Family Practice Sensitive Conditions (% of ED visits)	Q4 2010/11	28.0%	**33.8%**	**27%**	●	27%
◇Children Receiving Community Mental Health Treatment within 30 Days (%)	Q4 2010/11	79%	**96%**	**82.8%**	■	85%
Improving Access, Reducing Wait Times						
◇Hip Replacement Surgery Wait Time (90th percentile in weeks)	Q4 2010/11	36.6	**27**	**28.0**	■	28
◇Knee Replacement Surgery Wait Time (90th percentile in weeks)	Q4 2010/11	48.0	**27.5**	**42.0**	■	42

[¥] Annual Targets as per Performance Agreement.
◇Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.
[†] Interim target pending confirmation. Status based on interim target.
[*] Trend for these measures cannot be determined until subsequent data is available.
[^] Target under review.

Central Zone Performance Dashboard (continued)

Status

□	Performance is at or better than target, continue to monitor
△	Performance is within acceptable range of target, monitor and take action as appropriate
●	Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target¥
◇Cataract Surgery Wait Time (90th percentile in weeks)	Q4 2010/11	46.1	**26.7**	**36.0**	□	36
◇Other Scheduled Surgery Wait Time (90th percentile in weeks)	Q4 2010/11	26.3	**25.1**	**tbd**	na	tbd
◇Patients Discharged from ED or UCC within 4 hours (%) (Higher Volume EDs) £	Q4 2010/11	65%	**74%**	**70%**	□	70%
◇Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	Q4 2010/11	78%	**88%**	**82%**	□	82%
◇Patients Admitted from ED within 8 hours (%) (Higher Volume EDs) £	Q4 2010/11	44%	**54%**	**45%**	□	45%
◇Patients Admitted from ED within 8 hours (%) (All Sites) £	Q4 2010/11	55%	**76%**	**55%**	□	55%
Choice and Quality for Seniors						
◇People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	Q4 2010/11	471	**65**	**57**	●	57
◇People Waiting in Community for Continuing Care Placement	Q4 2010/11	1,110	**128**	**128**	□	128
◇Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	Q4 2010/11	47	**37**	**tbd**	na	tbd
◇Number of Home Care Clients	Q4 2010/11	56,041	**9,083***	**tbd**	na	tbd
Enabling Our People / Enabling One Health System						
◇Staff Overall Engagement (%)	2009/10	35%	**35%**	na	●	**43%**
◇Physician Overall Engagement (%)	2009/10	26%	**27%**	na	●	**43%**
◇Number of Netcare Users	Q4 2010/11	11,816	**na**	na	na	na

¥Annual Targets as per Performance Agreement.

◇Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.

* Trend for these measures cannot be determined until subsequent data is available.

£The Weekly ED Length of Stay (LOS) being published separate from this report are based upon a subset of the sites identified in the current ED LOS data definitions where more timely data is readily available. There is currently a three month time lag in obtaining information from alternate data sources that allow for a more complete provincial picture. AHS is currently working on integrating the data to support these measures using more timely data sources. Data are accurate to ±2%.

* Q4 2010/11 estimated for Central Zone.

Central Zone Performance Dashboard (continued)

Status

☐ Performance is at or better than target, continue to monitor

△ Performance is within acceptable range of target, monitor and take action as appropriate

● Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target¥
Quality and Patient Safety						
◇Patient Satisfaction - Addictions and Mental Health (AHS)	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q1 2011/12					
Percentage of Patient Feedback as Commendations	Q4 2010/11	9.12%	**3.59%**	**na**	na	tbd
Percentage of Patient Concerns Escalated to Patient Concerns Officer	Q4 2010/11	0.29%	**0%**	**na**	na	tbd
◇ Albertans Reporting Unexpected Harm	2010	9%	**8%**	na	☐	**9%**
◇ Patient Satisfaction Emergency Department	2010	59%	**63%**	na	na	**tbd**
◇ Patient Satisfaction Health Care Services Personally Received	2010	62%	**66%**	na	△	**65%**
◇ Patient Satisfaction Mental Health Services in Alberta	2010	78%	**82%**	na	na	**tbd**
Central Venous Catheter Bloodstream Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q1 2011/12					
◇Hospital Acquired MRSA Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2011/12					
◇Surgical Site Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2012/13					
C-Difficile Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q3 2011/2012					
Time to Resolve Patient Concerns	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q3 2011/2012.					
Never (Adverse) Events	Measurement proposed and being evaluated; no reporting strategy or start time available.					
Percent of patients diagnosed with diabetes with controlled blood sugar (haemoglobin A1c<8)	Measurement proposed and being evaluated; no reporting strategy or start time available.					
Percent of patients diagnosed with hypertension with blood pressure control	Measurement proposed and being evaluated; no reporting strategy or start time available.					
Number of continuing care facility residents transferred to acute care for fall-related injury	Measurement proposed and being evaluated; no reporting strategy or start time available.					

¥Annual Targets as per Performance Agreement.
◇Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.

Edmonton Zone Performance Dashboard

Status

□ Performance is at or better than target, continue to monitor
△ Performance is within acceptable range of target, monitor and take action as appropriate
● Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target¥
Staying Healthy / Improving Population Health						
◊Life Expectancy	2010	81.6	**81.8**	na	na	**na**
◊Potential Years of Life Lost (per 1,000 Population)	2010	44.8	**45.7**	na	na	**na**
Breast Cancer Screening Participation Rate	2008 - 2009	55.9%	**54.7%**	na	△†	**57%†** **2009-2010**
Cervical Cancer Screening Participation Rate	Jan 2007 - Dec 2009	70.7%	**70.1%**	na	△†	**72%†** **2008-2010**
Building a Primary Care Foundation						
◊Seniors (65+) Influenza Immunization Rate	2010/11	59%	**60%**	na	●	**75%**
◊Children (6 to 23 Months) Influenza Immunization Rate	2010/11	27%	**20%**	na	●	**75%^**
◊Childhood Immunization Rates for DTaP	2008	83.8%	**87.0%**	na	△	**95%**
◊Childhood Immunization Rates for MMR	2008	89.3%	**92.45%**	na	△	**95%**
Albertans Enrolled in a Primary Care Network (%)	Apr 2011	72%	**70%**	na	△	**75%**
◊Admissions for Ambulatory Care Sensitive Conditions (rate per 100,000 Population)	Q4 2010/11	74	**60**	**76**	□	304 (annually)
◊Family Practice Sensitive Conditions (% of ED visits)	Q4 2010/11	28.0%	**16.9%**	**27.3%**	□	27%
◊Children Receiving Community Mental Health Treatment within 30 Days (%)	Q4 2010/11	79%	**45%**	**82.8%**	●	85%
Improving Access, Reducing Wait Times						
◊ Urgent CABG Wait Time (90th percentile in weeks)	Q4 2010/11	2.2	**2.5**	**1.5**	●	1.5
◊ Semi-urgent CABG Wait Time (90th percentile in weeks)	Q4 2010/11	9.6	**15.5**	**5.0**	●	5.0
◊ Scheduled CABG Wait Time (90th percentile in weeks)	Q4 2010/11	19.9	**17.4**	**15.0**	●	15.0

¥Annual Targets as per Performance Agreements.
◊Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.
† Interim target pending confirmation. Status based on interim target.
* Trend for these measures cannot be determined until subsequent data is available.
^ Target under review.

Edmonton Zone Performance Dashboard (continued)

Status

□	Performance is at or better than target, continue to monitor
△	Performance is within acceptable range of target, monitor and take action as appropriate
●	Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target¥
◊Hip Replacement Surgery Wait Time (90th percentile in weeks)	Q4 2010/11	36.6	**49.8**	**28.0**	●	28
◊Knee Replacement Surgery Wait Time (90th percentile in weeks)	Q4 2010/11	48.0	**58.6**	**42.0**	●	42
◊Cataract Surgery Wait Time (90th percentile in weeks)	Q4 2010/11	46.1	**38**	**36.0**	△	36
◊Other Scheduled Surgery Wait Time (90th percentile in weeks)	Q4 2010/11	26.3	**26.1**	**tbd**	na	tbd
◊Radiation Therapy Access (referral to 1st consult) (90th percentile in weeks)	Q4 2010/11	5.5	**5.3**	**4.0**	●	4
◊Radiation Therapy Access (ready to treat to first therapy) (90th percentile in weeks)	Q4 2010/11	3.7	**3.9**	**4.0**	□	4
◊Patients Discharged from ED or UCC within 4 hours (%) (Higher Volume EDs) £	Q4 2010/11	65%	**57%**	**70%**	●	70%
◊Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	Q4 2010/11	78%	**64%**	**82%**	●	82%
◊Patients Admitted from ED within 8 hours (%) (Higher Volume EDs) £	Q4 2010/11	44%	**30%**	**45%**	●	45%
◊Patients Admitted from ED within 8 hours (%) (All Sites) £	Q4 2010/11	55%	**30%**	**55%**	●	55%
Choice and Quality for Seniors						
◊People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	Q4 2010/11	471	**151**	**129**	●	129
◊People Waiting in Community for Continuing Care Placement	Q4 2010/11	1,110	**310**	**254**	●	254
◊Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	Q4 2010/11	47	**45**	**tbd**	na	tbd
◊Number of Home Care Clients	Q4 2010/11	56,041	**20,205**	**tbd**	na	tbd

¥Annual Targets as per Performance Agreements.

◊Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.

* Trend for these measures cannot be determined until subsequent data is available.

£The Weekly ED Length of Stay (LOS) being published separate from this report are based upon a subset of the sites identified in the current ED LOS data definitions where more timely data is readily available. There is currently a three month time lag in obtaining information from alternate data sources that allow for a more complete provincial picture. AHS is currently working on integrating the data to support these measures using more timely data sources. Data are accurate to ±2%.

∞ Number of Home Care Clients – Q2 2010/11 data estimated for North Zone.

Edmonton Zone Performance Dashboard (continued)

Status

□	Performance is at or better than target, continue to monitor
△	Performance is within acceptable range of target, monitor and take action as appropriate
●	Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target¥
Enabling Our People / Enabling One Health System						
◇Staff Overall Engagement (%)	2009/10	35%	**37%**	na	●	**43%**
◇Physician Overall Engagement (%)	2009/10	26%	**25%**	na	●	**43%**
◇Number of Netcare Users	Q4 2010/11	11,816	**na**	**na**	na	na
Quality and Patient Safety						
◇Patient Satisfaction - Addictions and Mental Health (AHS)	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q1 2011/12					
Percentage of Patient Feedback as Commendations	Q4 2010/11	9.12%	**9.66%**	**na**	na	tbd
Percentage of Patient Concerns Escalated to Patient Concerns Officer	Q4 2010/11	0.29%	**0.12%**	**na**	na	tbd
◇ Albertans Reporting Unexpected Harm	2010	9%	**9%**	na	□	**9%**
◇ Patient Satisfaction Emergency Department	2010	59%	**55%**	na	na	**tbd**
◇ Patient Satisfaction Health Care Services Personally Received	2010	62%	**65%**	na	□	**65%**
◇ Patient Satisfaction Mental Health Services in Alberta	2010	78%	**75%**	na	na	**tbd**
Central Venous Catheter Bloodstream Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q1 2011/12					
◇Hospital Acquired MRSA Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2011/12					
◇Surgical Site Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2012/13					
C-Difficile Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q3 2011/2012					
Time to Resolve Patient Concerns	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q3 2011/2012.					
Never (Adverse) Events	Measurement proposed and being evaluated; no reporting strategy or start time available.					
Percent of patients diagnosed with diabetes with controlled blood sugar (haemoglobin A1c<8)	Measurement proposed and being evaluated; no reporting strategy or start time available.					
Percent of patients diagnosed with hypertension with blood pressure control	Measurement proposed and being evaluated; no reporting strategy or start time available.					
Number of continuing care facility residents transferred to acute care for fall-related injury	Measurement proposed and being evaluated; no reporting strategy or start time available.					

¥Annual Targets as per Performance Agreements.
◇Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.
✓Indicates data points that have been updated since the previous report.

North Zone Performance Dashboard

Status

□ Performance is at or better than target, continue to monitor
△ Performance is within acceptable range of target, monitor and take action as appropriate
● Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target¥
Staying Healthy / Improving Population Health						
◇Life Expectancy	2010	81.6	**79.8**	na	na	**na**
◇Potential Years of Life Lost (per 1,000 Population)	2010	44.8	**56.8**	na	na	**na**
Breast Cancer Screening Participation Rate	2008 - 2009	55.9%	**57.8%**	na	□†	**57%†** **2009-2010**
Cervical Cancer Screening Participation Rate	Jan 2007-Dec 2009	70.7%	**62.1%**	na	●†	**72%†** **2008-2010**
Building a Primary Care Foundation						
◇Seniors (65+) Influenza Immunization Rate	2010/11	59%	**49%**	na	●	**75%**
◇Children (6 to 23 Months) Influenza Immunization Rate	2010/11	27%	**18%**	na	●	**75%^**
◇Childhood Immunization Rates for DTaP	2008	83.8%	**78.2%**	na	●	**95%**
◇Childhood Immunization Rates for MMR	2008	89.3%	**89.24%**	na	△	**95%**
Albertans Enrolled in a Primary Care Network (%)	Apr 2011	72%	**63%**	na	●	**75%**
◇Admissions for Ambulatory Care Sensitive Conditions (rate per 100,000 Population)	Q4 2010/11	74	**125**	**76**	●	304 (annually)
◇Family Practice Sensitive Conditions (% of ED visits)	Q4 2010/11	28.0%	**38.8%**	**27.3%**	●	27%
◇Children Receiving Community Mental Health Treatment within 30 Days (%)	Q4 2010/11	79%	**79%**	**82.8%**	△	85%
Improving Access, Reducing Wait Times						
◇Hip Replacement Surgery Wait Time (90th percentile in weeks)	Q4 2010/11	36.6	**39.4**	**28.0**	●	28
◇Knee Replacement Surgery Wait Time (90th percentile in weeks)	Q4 2010/11	48.0	**43.1**	**42.0**	△	42

¥Annual Targets as per Performance Agreements.
◇Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.
† Interim target pending confirmation. Status based on interim target.
* Trend for these measures cannot be determined until subsequent data is available.
^ Target under review.

North Zone Performance Dashboard (continued)

Status

□	Performance is at or better than target, continue to monitor
△	Performance is within acceptable range of target, monitor and take action as appropriate
●	Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target[¥]
◇Cataract Surgery Wait Time (90th percentile in weeks)	Q4 2010/11	46.1	**47.1**	**36.0**	●	36
◇Other Scheduled Surgery Wait Time (90th percentile in weeks)	Q4 2010/11	26.3	**26.5**	**tbd**	na	tbd
◇Patients Discharged from ED or UCC within 4 hours (%) (Higher Volume EDs)[£]	Q4 2010/11	65%	**81%**	**70%**	□	70%
◇Patients Discharged from ED or UCC within 4 hours (%) (All Sites)[£]	Q4 2010/11	78%	**84%**	**82%**	□	82%
◇Patients Admitted from ED within 8 hours (%) (Higher Volume EDs)[£]	Q4 2010/11	44%	**70%**	**45%**	□	45%
◇Patients Admitted from ED within 8 hours (%) (All Sites)[£]	Q4 2010/11	55%	**84%**	**55%**	□	55%
Choice and Quality for Seniors						
◇People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	Q4 2010/11	471	**87**	**101**	□	101
◇People Waiting in Community for Continuing Care Placement	Q4 2010/11	1,110	**101**	**100**	△	100
◇Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	Q4 2010/11	47	**119**	**tbd**	na	tbd
◇Number of Home Care Clients	Q4 2010/11	56,041	**6,914**	**tbd**	na	tbd
Enabling Our People / Enabling One Health System						
◇Staff Overall Engagement (%)	2009/10	35%	**41%**	na	△	**43%**
◇Physician Overall Engagement (%)	2009/10	26%	**27%**	na	●	**43%**
◇Number of Netcare Users	Q4 2010/11	11,816	**na**	**na**	na	na

[¥] Annual Targets as per Performance Agreements.

◇Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.

* Trend for these measures cannot be determined until subsequent data is available.

[£] The Weekly ED Length of Stay (LOS) being published separate from this report are based upon a subset of the sites identified in the current ED LOS data definitions where more timely data is readily available. There is currently a three month time lag in obtaining information from alternate data sources that allow for a more complete provincial picture. AHS is currently working on integrating the data to support these measures using more timely data sources. Data are accurate to ±2%.

∞ Number of Home Care Clients – Q2 2010/11 data estimated for North Zone.

North Zone Performance Dashboard (continued)

Status

□ Performance is at or better than target, continue to monitor

△ Performance is within acceptable range of target, monitor and take action as appropriate

● Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target¥
Quality and Patient Safety						
◇Patient Satisfaction - Addictions and Mental Health (AHS)	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q1 2011/12					
Percentage of Patient Feedback as Commendations	Q4 2010/11	9.12%	**2.05%**	**na**	na	tbd
Percentage of Patient Concerns Escalated to Patient Concerns Officer	Q4 2010/11	0.29%	**0%**	**na**	na	tbd
◇ Albertans Reporting Unexpected Harm	2010	9%	**8%**	na	□	**9%**
◇ Patient Satisfaction Emergency Department	2010	59%	**58%**	na	na	**tbd**
◇ Patient Satisfaction Health Care Services Personally Received	2010	62%	**53%**	na	●	**65%**
◇ Patient Satisfaction Mental Health Services in Alberta	2010	78%	**78%**	na	na	**tbd**
Central Venous Catheter Bloodstream Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q1 2011/12					
◇Hospital Acquired MRSA Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2011/12					
◇Surgical Site Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2012/13					
C-Difficile Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q3 2011/2012					
Time to Resolve Patient Concerns	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q3 2011/2012.					
Never (Adverse) Events	Measurement proposed and being evaluated; no reporting strategy or start time available.					
Percent of patients diagnosed with diabetes with controlled blood sugar (haemoglobin A1c<8)	Measurement proposed and being evaluated; no reporting strategy or start time available.					
Percent of patients diagnosed with hypertension with blood pressure control	Measurement proposed and being evaluated; no reporting strategy or start time available.					
Number of continuing care facility residents transferred to acute care for fall-related injury	Measurement proposed and being evaluated; no reporting strategy or start time available.					

¥Annual Targets as per Performance Agreements.

◇Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.

Alberta Health
Services

Treatment Level Activity Report

Activity Measure	2008/09 Fiscal Year	2009/10 Q1	2009/10 Q2	2009/10 Q3	2009/10 Q4	2009/10 Fiscal Year	2010/11 Q1	2010/11 Q2	2010/11 Q3	2010/11 Q4	2010/11 Fiscal Year
Number of Hospital Discharges[1] (by Site)	357,392	92,920	89,642	89,683	90,069	362,314	92,634	89,129	89,957	92,301	364,021
Average Hospital Length of Stay (Days) [1,2] (by Site)	6.9	6.9	6.8	7.1	6.9	6.9	6.8	6.9	7.2	7.1	7.0
Per Cent of Alternate Level of Care (ALC) [1,3] Days	8.4%	8.2%	8.9%	10.9%	9.4%	9.4%	8.2%	9.9%	10.0%	8.0%	9.0%
Number of Hospital Births[1]	50,227	13,085	13,440	12,230	11,983	50,738	12,882	12,985	11,952	11,937	49,756
Number of Emergency Department Visits[4] (by Site)	1,921,151	501,685	494,297	482,639	474,182	1,952,803	491,908	491,130	472,001	486,759	1,941,798
Number of Urgent Care Service (UCS) Visits[5]	103,528	29,730	30,075	29,561	36,550	125,916	44,198	44,215	42,364	46,381	177,158
Number of Health Link Calls	864,240	205,649	190,883	433,586	200,074	1,030,192	175,319	167,602	203,281	212,769	758,971
Number of Total Primary Hip Replacements[6]	2,754	775	640	806	910	3,131	833	667	795	861	3,156
Number of Total Primary Knee Replacements[6]	3,811	1,079	871	1,060	1,118	4,128	1,225	897	1,132	1,141	4,395
Number of Cataract Surgeries	27,682	7,320	6,024	6,650	8,607	28,601	7,555	7,214	8,019	10,926	33,714
Number of MRI Exams[7]	157,724	41,302	40,432	38,960	45,254	165,948	45,008	43,369	40,389	48,656	177,422
Number of CT Exams[8]	418,373	91,584	88,972	84,801	85,424	350,781	88,727	87,485	77,670	79,281	333,163
Number of Lab Tests[9]	56,506,010	15,143,422	14,401,121	14,382,996	15,207,661	59,135,200	15,833,877	14,942,683	15,263,436	15,220,262	61,260,258

Notes: * 2010/11 figures are preliminary, pending data verification.

N/A – These measures rely on abstracted data which is completed and available for reporting approximately 2-3 months post discharge.

1. **The above figures exclude Grimshaw/Berwyn and District Community Health Centre as inpatient data abstracts are not submitted.**
2. **Average Hospital Length of Stay (Days) includes acute, subacute and Alternate Level of Care (ALC) days.**
3. **Alternate Level of Care (ALC) Days is the per cent of total hospital days. Use with caution as classification of ALC days is not standardized throughout the province.**
4. **Number of Emergency Department Visits excludes the following facilities: Breton Health Centre, Coaldale Health Centre, Rainbow Lake Health Centre, St. Mary's Health Care Centre (Trochu).**
5. **Number of Urgent Care Service (UCS) Visits: Figures are based on the certification effective dates below.**

Airdrie Regional Health Centre	**18-Dec-2009**
Cochrane Community Health Centre	**15-Feb-2011**
Health First Strathcona	**01-May-2008**
Okotoks Health and Wellness Centre	**17-Mar-2010**
Sheldon M Chumir Centre	**01-Apr-2008**
South Calgary Health Centre	**01-May-2008**

6. **Number of Total Primary Hip Replacements and Number of Total Primary Knee Replacements data source is inpatient data abstracts reported as of discharge date.**
7. **Number of MRI Exams: Figures include exams performed by Covenant Health DI sites. 2009/10 figures include outsourced exams.**
8. **Number of CT Exams: Figures include exams performed by Covenant Health DI sites. CT exam count converted to new (lower) exam values effective April 1, 2009 for all regions except former Capital Health; former Capital Health converted effective Oct 1, 2010.**
9. **Lab Tests: Volumes are not comparable to numbers reported in previous periods (prior to April 2009). Figures include tests performed in non-AHS facilities.**

Performance Measure Update

Life Expectancy

Data updated annually.
Most current data is 2010.
Next data update expected for Q4 2011/12.

PERFORMANCE STATUS

Performance improvement observed since last reported period.
Baseline 2008: 80.59 years

TARGET:
Not Specific

2010 ACTUAL: 81.6 years

WHAT IS BEING MEASURED?

Life expectancy is the number of years from birth a person would be expected to live based on mortality statistics.

Detailed indicator definition is available.

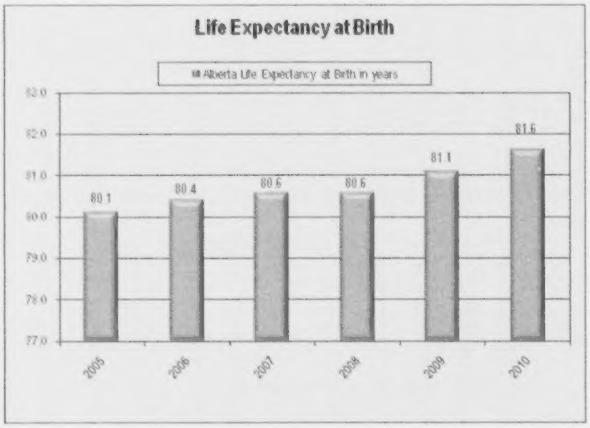
WHY IS THIS IMPORTANT?

Life expectancy at birth is an indicator of the health of a population, measuring the number of years lived rather than the quality of life.

WHAT IS THE TARGET?

Alberta Health Services (AHS) targets an increase in life expectancy in a manner consistent with the Canadian average, with the goal of being above the national average.

Over the next five years, there is an expectation that disparities in life expectancy throughout various AHS zones in the province will decrease, and that there will be an increase in life expectancy among First Nations populations.



Source: Alberta Health & Wellness

HOW ARE WE DOING?

There is significant disparity in life expectancy between urban and rural zones. Life expectancy in the North is about two years less than for the average Albertan. As well, a child born in the Edmonton Zone can expect to live a year less than a child born in Calgary. Differences in health status and determinants of health are also evident between rural and urban areas.

WHAT ACTIONS ARE WE TAKING?

Recent health promotion initiatives that have been piloted – and will be expanded in the future – include programs for community and family-based obesity prevention and weight management, as well as quitting smoking (e.g. promotion of an "Alberta quits" helpline and website, tobacco cessation training delivered to over 1,200 health professionals, and establishment of group cessation programs in communities). More broadly, AHS is working to improve population health through integrating health promotion and disease and injury prevention programs with other health care delivery services, and better coordination between health and other government and municipal sectors.

WHAT ELSE DO WE KNOW?

The leading causes of death are cancer, ischemic heart diseases, cerebrovascular diseases (stroke), chronic lower respiratory diseases and accidents. Almost 60 per cent of the deaths in Alberta are due to cancer and circulatory diseases. These causes of death need to be carefully considered to determine opportunities to improve life expectancy.

Information is available by zone and First Nations status.

HOW DO WE COMPARE?

Using a similar definition, Alberta ranked fourth among the 10 provinces for life expectancy. Alberta = 80.5, Best Performing Province = 81.2 (British Columbia), Canada = 80.7 (Statistics Canada, 2005/2007)

Performance Measure Update

Potential Years of Life Lost

Data updated annually.
Most current data is 2010.
Next data update expected for Q4 2011/12.

WHAT IS BEING MEASURED?

Potential years of life lost (PYLL) is the number of years of life "lost" per 1,000 population when a person dies from any cause before age 75. For example, if a person died at age 25, then 50 years of life has been lost. The total potential years of life lost is divided by the total population under age 75.

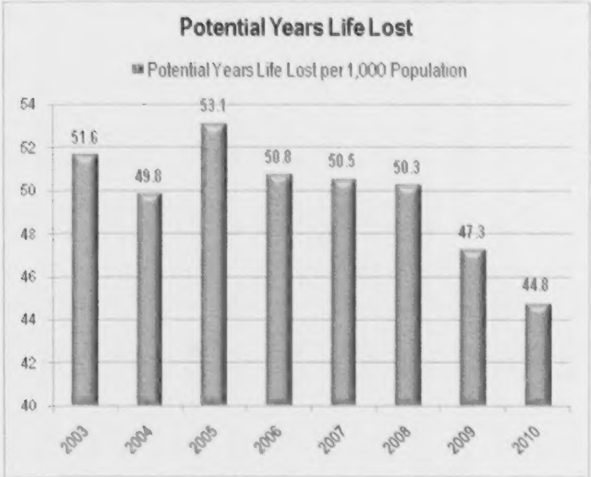
Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

PYLL is an indicator of premature mortality that gives greater weight to causes of death that occur at a younger age than to those at older ages. It emphasizes the loss of life at an early age and the causes of early deaths such as cancer, injury and cardiovascular disease. For example, the death of a person 40 years old contributes one death and 35 PYLL; whereas the death of a 70-year old contributes one death but only five years to PYLL.

WHAT IS THE TARGET?

There is an expectation that PYLL will be monitored, and that improvements will be seen in PYLL over the next five years.



Source: Alberta Health & Wellness

PERFORMANCE STATUS

Performance improvement observed since last reported period.
Baseline 2009: 47.3 years

TARGET:
Not Specific

2010 ACTUAL:
44.8 years

HOW ARE WE DOING?

In 2010, there was an improvement in PYLL with a drop from 47.3 years per 1,000 population in 2009 to 44.8 years per 1,000 population in 2010.

WHAT ACTIONS ARE WE TAKING?

Recent health promotion initiatives that have been piloted – and will be expanded in the future – include programs for community and family-based obesity prevention and weight management, as well as quitting smoking (e.g. promotion of an "Alberta quits" helpline and website, tobacco cessation training delivered to over 1,200 health professionals, and establishment of group cessation programs in communities). More broadly, AHS is working to improve population health through integrating health promotion and disease and injury prevention programs with other health care delivery services, and better coordination between health and other government and municipal sectors.

WHAT ELSE DO WE KNOW?

PYLL rates for Alberta are calculated by cause of death as follows: all causes, cancer, colorectal cancer, lung cancer, diseases of the circulatory system, ischaemic heart diseases, cerebrovascular diseases (stroke), diseases of the respiratory system, external causes (injury), unintentional injury, land transport and intentional self-harm (suicide).

Information is available by zone and sex.

HOW DO WE COMPARE?

Using a similar definition, Alberta ranked third among the 10 provinces for PYLL. Alberta = 49.9, Best Performing Province = 44.4 (Ontario), Canada = 49.0 (Statistics Canada, 2005/2007)

Performance Measure Update

Data updated annually.
Most current data is 2008.
Next data update expected for Q1 2011/12.

Colorectal Cancer Screening Participation Rate

PERFORMANCE STATUS

Status to be determined.

2010 TARGET: 37%
(to be confirmed)

2008 ACTUAL: 35.5%

WHAT IS BEING MEASURED?

The colorectal cancer (CRC) screening participation rate measures the percentage of Albertans between the ages of 50 and 74 years who have had at least one of the following tests for screening: a Fecal Occult Blood Test (FOBT) within the last two years, a flexible sigmoidoscopy within the last five years, or a colonoscopy within the last ten years.

Screening refers to the use of a test for a person without symptoms or signs of colorectal cancer.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

Death from colorectal cancer is 90 per cent preventable if the disease is caught at early stages. There is substantial evidence that organized colorectal cancer screening can reduce the mortality and incidence of colorectal cancer, and will significantly reduce the suffering and substantial costs of end stage colorectal cancer treatment.

WHAT IS THE TARGET?

The Alberta 2015 target is for 55 per cent of individuals to have had a Fecal Occult Blood Test (FOBT) within the last two years, a flexible sigmoidoscopy within the last five years, or a colonoscopy within the last ten years. The 2010 target is 37 per cent. A target of 67 per cent has been set for 2020.

HOW ARE WE DOING?

The 2008 Canadian Community Health Survey (CCHS) showed 35.5 per cent of Albertans between the ages of 50 and 74 years reported having a fecal test within the past two years, or flexible sigmoidoscopy or colonoscopy within the past five years.

Table: Percentage of population aged 50-74 who are up to date for colorectal cancer screening (2008)

Province	Screening Rate (%)
Alberta	35.5%

Source: Canadian Community Health Survey (CCHS) 2008

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Resources and education to healthcare providers to promote cancer screening is ongoing, as are outreach screening services to rural and hard-to-reach populations in order to reduce disparities in cancer screening participation. As well, over 100,000 letters have been sent to target populations for breast, cervical and colorectal cancer screening in the past three months. In addition, a business case for a province-wide colorectal cancer screening program has been developed to establish consistent practices and reduce wait times for colorectal cancer screening.

Subsequent actions planned: New partnerships will be tested between Patient Care Networks, Laboratory Services and the provincial screening program to enhance colorectal cancer screening. In addition, implementation will continue on a long-term social marketing campaign and community action strategy to enhance public knowledge, attitudes and behaviours towards cancer screening participation.

WHAT ELSE DO WE KNOW?

The changes to colorectal cancer screening participation are gradual and may be affected by many factors, including an individuals' knowledge and attitude toward colorectal cancer screening, access to services, as well as seasonal variation and service interruptions, therefore annual reporting would provide more meaningful information.

As with other population surveys, CCHS provides cross-sectional data with information self-reported and/or recalled. Data quality issues from survey methodology may exist.

HOW DO WE COMPARE?

Alberta ranked fourth among the 10 provinces for self-reported colorectal cancer screening. Alberta = 35.5 per cent, Best Performing Province = 54.6 per cent, Canada = 39.7 per cent (Statistics Canada, 2008).

Performance Measure Update

Data updated annually.
Most current data is 2008-2009.
Next data update expected for Q1 2011/12.

Breast Cancer Screening Participation Rate

PERFORMANCE STATUS

Status to be determined.

2009-2010 TARGET: 57%
(to be confirmed)

2008-2009 ACTUAL: 55.9%

WHAT IS BEING MEASURED?

The breast cancer screening participation rate measures the percentage of women in Alberta between the ages of 50 and 69 years who have had a breast screening mammogram in the last two years (biennially).

Women who are not eligible for screening mammograms are included in the data. That is, women who have had breast cancer, breast symptoms, breast implants,or prophylactic bilateral mastectomies are not removed. This leads to a slight underestimate in the screening mammogram participation rate.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

Adequate participation in breast cancer screening is essential for reductions in mortality for women between the ages of 50 and 69 years. Regular screening following clinical practice guidelines can identify unsuspected breast cancer at a stage when early intervention can positively affect the outcome. The goal is to reduce breast cancer mortality through early detection when treatment is more likely to be effective.

WHAT IS THE TARGET?

The Alberta target is for 70 per cent of eligible women 50 to 69 years of age to have a screening mammogram at least biennially by 2020. The 2009-2010 target is 57 per cent.

Table: Percentage of women 50-69 who have a screening mammogram at least biennially

Time Period	Target Population (Alberta)	Number of Women Screened	Screening Rate (%)
2007 - 2008	354,216	195,005	55.1%
2008 - 2009	371,359	207,617	55.9%

Source: Alberta Breast Cancer Screening Program (ABCSP) and Alberta Health and Wellness (AHW).

HOW ARE WE DOING?

During the two-year period between January 2008 and December 2009, 55.9 per cent of women aged 50 to 69 years received a screening mammogram. The rate for 2009-2010 is not yet available.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Resources and education to healthcare providers to promote cancer screening is ongoing, as are outreach screening services to rural and hard-to-reach populations in order to reduce disparities in cancer screening participation (e.g. mobile breast cancer screening services were provided to over 4,400 clients in 28 rural communities in the past three months). As well, over 100,000 letters have been sent to target populations for breast, cervical and colorectal cancer screening in the past three months.

Subsequent actions planned: In addition to continued social marketing efforts, a community action strategy will be implemented to increase cancer screening participation rates for un/under-screened groups at the community level.

WHAT ELSE DO WE KNOW?

In order to more accurately reflect the way in which the population receives screening mammography, the Alberta Breast Cancer Screening Program is working with the Public Health Agency of Canada to evaluate a biennial mammography utilization indicator that might include bilateral diagnostic mammograms in addition to screening mammograms.

Information is available by zone.

HOW DO WE COMPARE?

Using a similar definition, Alberta tied with New Brunswick for first among the 10 provinces for self-reported mammography. Alberta = 74.0 per cent, Best performing province = 74.0 per cent (Alberta and New Brunswick), Canada = 72.5 per cent (Statistics Canada, 2008)

Performance Measure Update

Data updated annually.
Most current data is 2007-2009.
Next data update expected for Q1 2011/12.

Cervical Cancer Screening Participation Rate

PERFORMANCE STATUS

Status to be determined.

2008-2010 TARGET: 72% (to be confirmed)

2007-2009 ACTUAL: 70.7%

WHAT IS BEING MEASURED?

The cervical cancer screening participation rate measures the percentage of women between the ages of 21 and 69 years who have had a Pap test in the last three years.

Women who are not eligible for Pap tests due to hysterectomy are included in the data. This leads to a slight underestimate in the Pap test screening participation rate.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

Research indicates that over 90 per cent of cervical cancers can be cured when detected early and treated. Widespread Pap testing in Alberta over the past 40 years has resulted in a significant reduction in cervical cancer mortality. Nevertheless, failure to be screened, and under screening, remain the most important risk factors for cervical cancer in Alberta women. There is also strong evidence of disparities in coverage across Alberta by geography, socioeconomic status and ethnicity. Cervical cancer is almost entirely preventable through the effective application of cervical screening and human papillomavirus (HPV) immunization.

WHAT IS THE TARGET?

The Alberta target is for 70 per cent of eligible women 21 to 69 years of age to have a Pap test every three years. The target for 2008-2010 is 72 per cent.

HOW ARE WE DOING?

During the three-year period between January 2007 and December 2009, 70.7 per cent of eligible women aged 21 to 69 years received a screening Pap test. This screening rate meets the Alberta Health Services target rate of 70 per cent.

Table: Percentage of women aged 21-69 who have had a Pap test at least every three years

Time Period	Target Population (Alberta)	Number of Women Screened	Screening Rate (%)
2005-2007	1,061,565	755,682	71.2%
2006-2008	1,095,468	782,421	71.4%
2007-2009	1,133,789	802,137	70.7%

Source: Extracted from AHW FFS data

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Resources and education to healthcare providers to promote cancer screening is ongoing, as are outreach screening services to rural and hard-to-reach populations in order to reduce disparities in cancer screening participation. As well, over 100,000 letters have been sent to target populations for breast, cervical and colorectal cancer screening in the past three months. In addition, the Alberta Cervical Cancer Screening Program (ACCSP) continues its work to enhance screening (e.g. mailing Pap test results, sending reminder letters if women are overdue for their next Pap test).

Subsequent actions planned: The ACCSP will continue to be expanded across the province. Implementation will also continue on a long-term social marketing campaign and community action strategy to enhance public knowledge, attitudes and behaviours towards cancer screening participation. In addition, a community action strategy will be implemented to increase cancer screening participation rates for un/under-screened groups at the community level.

WHAT ELSE DO WE KNOW?

Pap test coverage tends not to be evenly distributed, with coverage rates of less than 40 per cent in some communities.

Information is available by zone.

HOW DO WE COMPARE?

Using a similar definition, Alberta ranked fourth among the 10 provinces for self-reported cervical cancer screening. Alberta = 76.6 per cent, Best Performing Province = 81.0 per cent (Nova Scotia), Canada = 72.8 per cent (Statistics Canada, 2005)

Performance Measure Update

Seniors (65+) Influenza Immunization Rate

Data updated annually.
Most current data is 2010/11.
Next data update expected for Q4 2011/12.

WHAT IS BEING MEASURED?

The percentage of seniors aged 65 and older who have received the seasonal influenza vaccine during the previous influenza season (Oct 2010 through Apr 2011).

Data on immunizations comes from AHS Zones and the First Nations and Inuit Health (FNIH), Health Canada, Alberta Region. Seniors in Lloydminster primarily receive immunizations from Saskatchewan Health and are likely missing from the numerator count; as such the Lloydminster population has been removed from the denominator.

Detailed indicator definition is available.

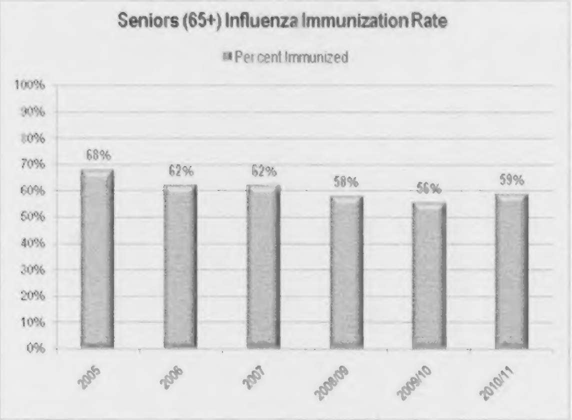
WHY IS THIS IMPORTANT?

A high rate of seasonal influenza immunization among seniors will reduce the incidence of complications and death associated with influenza disease in this population.

Providing influenza immunization to eligible Albertans is a major activity of the public health system. A high rate of coverage will reduce the impact of disease on the healthcare system.

WHAT IS THE TARGET?

The Alberta Health and Wellness (AHW) target is for 75 per cent of seniors 65 years of age and older to have received one dose of seasonal influenza vaccine.



Source: Alberta Health & Wellness; figures are preliminary calculations from AHS.

● **PERFORMANCE STATUS**

Performance is outside acceptable range, take action and monitor progress.
Baseline 2008/09: 60%

2010/11 TARGET: 75%

2010/11 ACTUAL: 59%

HOW ARE WE DOING?

The 2010/11 seasonal influenza immunization rate for seniors aged 65 and older is 59 per cent. The rate is below the target of 75 per cent.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A number of steps were taken to enhance immunization coverage for the seniors population during the 2010/11 influenza season, including the engagement of a range of community partners who offered the vaccine (pharmacies and physician offices), the establishment of targeted clinics for seniors, as well as the administration of vaccine for home-bound seniors. In addition, the first in a series of planning meetings for the 2011/12 season was held in February 2011 with representatives from AHS and Alberta Health and Wellness, along with physicians, pharmacists and other health care providers to discuss strategies to optimize immunization coverage next season.

Subsequent actions planned: Development of the 2011/12 seasonal influenza immunization campaign will continue over the coming months under Steering Committee leadership.

WHAT ELSE DO WE KNOW?

A high rate of coverage will reduce the impact of disease on the healthcare system during influenza season, including physician and emergency department visits, and hospitalizations. The lower immunization rate for 2009/10 may be due to seniors choosing the pandemic H1N1 vaccine component because it was known to be the circulating strain.

Information is available by zone.

HOW DO WE COMPARE?

Using a similar definition, Alberta ranked fifth among the 10 provinces for self-reported influenza immunization. Alberta = 63.9 per cent, Best Performing Province = 72.8 per cent (Nova Scotia), Canada = 66.5 per cent (Statistics Canada, 2009)

Data updated annually.
Most current data is 2010/11.
Next data update expected for Q4 2011/12.

Children (6 to 23 Months) Influenza Immunization Rate

WHAT IS BEING MEASURED?

The percentage of children between the ages of six and 23 months who have received the recommended doses of seasonal influenza vaccine is measured.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

A high rate of seasonal influenza immunization among children reduces the incidence of complications and death associated with influenza disease and reduces the spread of disease to older age groups during the influenza season.

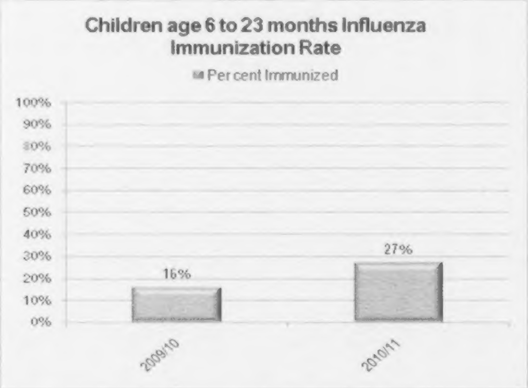
Providing influenza immunizations to eligible Albertans is a major activity of the public health system. A high rate of coverage will reduce the impact of disease on the healthcare system.

WHAT IS THE TARGET?

The Alberta Health and Wellness (AHW) target is for 75 per cent of children aged six to 23 months to have received the recommended doses of seasonal influenza vaccine.

HOW ARE WE DOING?

The influenza immunization rate for children between the ages of 6-23 months was 27 per cent for 2010/11, well below target.



Source: Alberta Health & Wellness and Alberta Health Services; figures are preliminary calculations from AHS.

Notes for 2009/10: Immunization data is representative of four Alberta Health Services (AHS) Zones (South, Calgary, Central and Edmonton). Data is not complete due to issues with the Immunization coverage rate reporting system (MediTech) in parts of the province. Data is also not available from First Nations and Inuit Health (FNIH), Health Canada, Alberta Region.
Methodology was corrected 2009/10 forward to reflect children requiring two doses for immunity.

PERFORMANCE STATUS

Performance is outside acceptable range, take action and monitor progress.

2010/11 TARGET: 75%

2010/11 ACTUAL: 27%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A number of steps were taken to enhance child immunization coverage during the 2010/11 influenza season, including the administration of vaccine when children presented for routine immunizations in child health clinics. In addition, the first in a series of planning meetings for the 2011/12 season was held in February 2011 with representatives from AHS and AHW, along with physicians, pharmacists and other health care providers to discuss strategies to optimize immunization coverage next season.

Subsequent actions planned: Development of the 2011/12 seasonal influenza immunization campaign will continue over the coming months under Steering Committee leadership.

WHAT ELSE DO WE KNOW?

Children receiving influenza vaccine for the first time require two doses. Poor uptake for the needed second dose is common. The 2009/10 rate is believed to be lower than previous years as many parents chose to have their children receive only the pandemic H1N1 vaccine. Methods of data collection have been inconsistent in previous years and rates are not directly comparable. AHS is working with AHW to standardize data collection and reporting of this indicator.

Information is available by zone.

HOW DO WE COMPARE?

Limited comparable data is available.

Childhood Immunization Rate Diphtheria, Tetanus, Pertussis, Polio and *Haemophilus* Influenza type B

Data updated annually.
Most current data is 2008.
Next data update to be confirmed.

PERFORMANCE STATUS

Performance is outside acceptable range, take action and monitor progress.

2010/11 TARGET: 95%

2008 ACTUAL: 83.8%

WHAT IS BEING MEASURED?

Childhood immunization rates for Diphtheria, Tetanus and Pertussis (DTaP) measures the percentage of children who have received the required number of doses of DTaP vaccine by two years of age.

Data on children receiving combined components of the DTaP-IPV-Hib vaccine is currently not available from all AHS Zones. As coverage rates for DTaP-IPV and Hib are reported separately in some Zones, DTaP is used as the proxy measure. Data on immunizations comes from AHS Zones and the First Nations and Inuit Health (FNIH), Health Canada, Alberta Region.

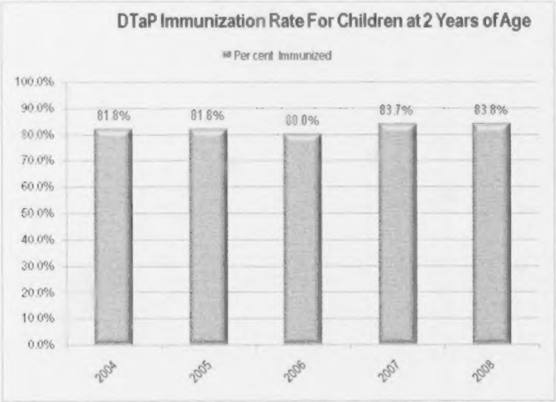
Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

A high rate of immunization for a population reduces the incidence of vaccine preventable childhood diseases, and controls outbreaks. Immunizations protect children and adults from a number of preventable diseases, some of which can be fatal or produce permanent disabilities. A high rate of coverage is needed to protect the entire community from outbreaks of the disease.

WHAT IS THE TARGET?

The Alberta Health and Wellness (AHW) Business Plan target is for 95 per cent of children to have received the required number of doses of DTap-IPV-Hib vaccine by two years of age.



Source: Alberta Health & Wellness and Alberta Health Services

HOW ARE WE DOING?

The DTaP immunization rate for children by two years of age for 2008 is 83.8 per cent (below target). The rate for 2009 is not yet available.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: An Immunization Steering Committee has been created to investigate strategies to improve immunization coverage, with two initiatives already underway: (1) an exhaustive literature review of evidence-based strategies to improve immunization rates; and (2) an environmental scan of currently implemented strategies within each Zone. In addition, plans have been completed to enable more timely reporting of immunization coverage. This will involve obtaining coverage rates from each zone-based system.

Subsequent actions planned: New processes to improve on the timeliness and frequency of immunization reporting are slated to come into effect later in 2011.

WHAT ELSE DO WE KNOW?

There are pockets of low immunization across the province. Specific strategies need to be developed to increase the immunization rate closer to the target by identifying why some children are not immunized, to increase access and modify existing immunization delivery programs to best suit the local population.

Information is available by zone.

HOW DO WE COMPARE?

Limited comparable data is available. In 2007, Manitoba reported 73.3 per cent of children were complete for DTaP, 88.0 per cent for Polio and 79.3 per cent for Hib by the age of two years. British Columbia reported that 73.3 per cent of children born in 2008 were up-to-date by two years of age for DTaP/IPV/HIB (BC Centre for Disease Control 2010).

Performance Measure Update

Childhood Immunization Rate for Measles, Mumps, Rubella

Data updated annually.
Most current data is 2008.
Next data update to be confirmed.

PERFORMANCE STATUS

Performance is within acceptable range, monitor and take action as appropriate.

2010/11 TARGET: 95%

2008 ACTUAL: 89.3%

WHAT IS BEING MEASURED?

The childhood immunization rate for Measles, Mumps and Rubella (MMR) measures the percentage of children who have received the required number of doses of MMR vaccine by two years of age.

Data on immunizations comes from Alberta Health Services (AHS) Zones and the First Nations and Inuit Health (FNIH), Health Canada, Alberta Region.

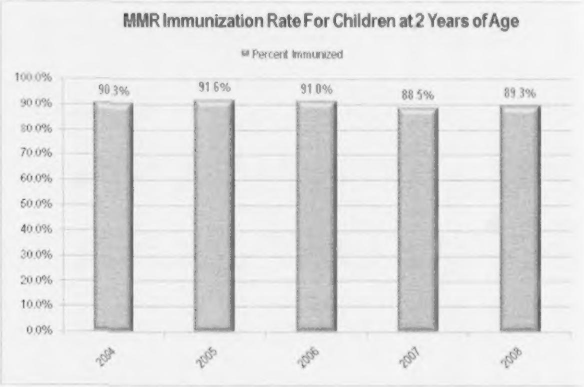
Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

A high rate of immunization for a population can help ensure that the incidence of childhood diseases remains low and outbreaks are controlled. Providing immunizations for childhood diseases is a major activity of the public health system. Immunizations protect children and adults from a number of diseases, some of which can be fatal or produce permanent disabilities. A high rate of coverage is needed to protect the entire community from outbreaks of the disease.

WHAT IS THE TARGET?

The Alberta Health and Wellness (AHW) Business Plan target is for 95 per cent of children to have received the required number of doses of MMR vaccine by two years of age.



Source: Alberta Health & Wellness and Alberta Health Services

HOW ARE WE DOING?

The 2008 MMR immunization rate for children at two years of age is 89.3 per cent (below target). The rate for 2009 is not yet available.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: An Immunization Steering Committee has been created to investigate strategies to improve immunization coverage, with two initiatives already underway: (1) an exhaustive literature review of evidence-based strategies to improve immunization rates; and (2) an environmental scan of currently implemented strategies within each Zone. In addition, plans have been completed to enable more timely reporting of immunization coverage. This will involve obtaining coverage rates from each zone-based system.

Subsequent actions planned: New processes to improve on the timeliness and frequency of immunization reporting are slated to come into effect later in 2011.

WHAT ELSE DO WE KNOW?

There are pockets of low immunization across the province. Specific strategies need to be developed to increase immunization rates closer to the target by identifying why some children are not immunized, to increase access and modify existing immunization delivery programs to best suit the local population.

Information is available by zone.

HOW DO WE COMPARE?

Limited comparable data is available. In 2007, Manitoba reported 86.5 per cent of children were complete for Measles, 86.4 per cent for Mumps and 86.4 per cent for Rubella by two years. British Columbia reported that 73.7 per cent of children born in 2008 were up-to-date by two years of age for MMR (BC Centre for Disease Control 2010).

Performance Measure Update

Data updated twice yearly.
Most current data is April 2011.
Next data update expected for Q3 2011/12.

Albertans Enrolled in a Primary Care Network (%)

△ **PERFORMANCE STATUS**

Performance is within acceptable range, monitor and take action as appropriate. Baseline Apr 2009: 59%

2010/11 TARGET: 75%

ACTUAL: 72%
April 2011

WHAT IS BEING MEASURED?

The percentage of Albertans enrolled in a Primary Care Network (PCN) measures the proportion of Albertans who are attached to a physician working within a PCN.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

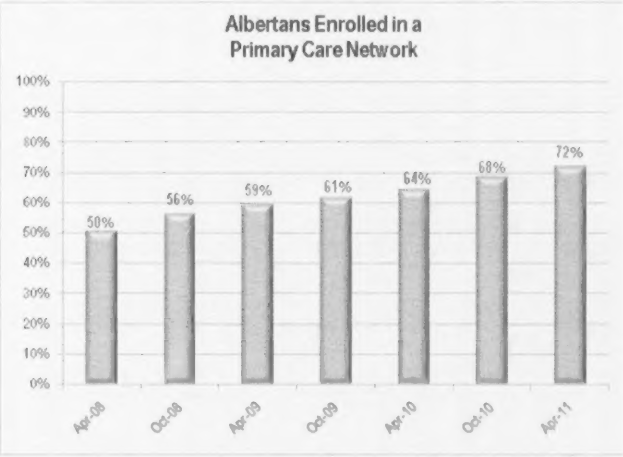
A PCN is an arrangement between a group of family physicians and Alberta Health Services (AHS) to provide and coordinate a comprehensive set of primary health care services to patients. Primary Care is the care individuals receive at the first point of contact with the healthcare system. Patients receive care for their everyday health needs, including prevention, diagnosis and treatment of health conditions, as well as health promotion.

WHAT IS THE TARGET?

AHS has established a target of 75 per cent of Albertans enrolled in a PCN for 2010/11.

HOW ARE WE DOING?

The percentage of Albertans enrolled in a PCN is 72 per cent as of April 2011, which is below the 2010/11 target of 75 per cent.



Source: Alberta Health & Wellness; Apr 2010 figure is a preliminary calculation from AHS

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: AHS Zones are actively recruiting new physicians to form PCNs or to join existing PCNs. New PCNs have also been established recently in Grande Prairie (Oct/2010), Lloydminster (Jan/2011) and Wainwright (Apr/2011), with five more prospective PCNs currently at the Letter of Intent stage. In addition, work is ongoing to increase enrolment of specific populations (e.g. palliative patients and new mothers with babies).

Subsequent actions planned: AHS and its partners will continue to create new PCNs and also recruit new and existing physicians to PCNs currently in operation. Work is also ongoing to recruit patients not yet attached to a physician. Lastly, all partners will continue to work collaboratively to improve efficiency, patient and provider satisfaction, and increased PCN participation within the framework of a primary care model that supports physicians, teams and best practice.

WHAT ELSE DO WE KNOW?

Alberta Health Services is working to apply and advance a patient-focused model of primary health care that offers care in the community, and provides a team-based health care provider approach.

Information is available by zone.

Reference: Primary Care Initiative Program Office

HOW DO WE COMPARE?

Alberta ranked ninth among the 10 provinces for self-reports of having a regular medical doctor. Alberta = 80.6 per cent, Best Performing Province = 92.8 per cent (Nova Scotia), Canada = 84.9 per cent (Statistics Canada, 2009). Alberta ranked fifth among the 10 provinces in terms of number of family physicians per 100,000 population. Alberta = 112, Best Performing Province = 119 (Nova Scotia), Canada = 101 (Canadian Institute for Health Information, 2008)

Performance Measure Update

Data updated quarterly.
Most current data is Q4 2010/11.
Next data update expected for Q1 2011/12.

Admissions for Ambulatory Care Sensitive Conditions

PERFORMANCE STATUS

Performance is at or better than target, continue to monitor.

Baseline 2007-09: 309 annually

2010/11 TARGET: 304
admissions per 100,000
Q4 TARGET: 76

Q4 ACTUAL: 74
admissions per 100,000

WHAT IS BEING MEASURED?

Admissions for Ambulatory Care Sensitive Conditions (ACSCs) measures the acute care hospitalization rate for Albertans younger than age 75 years, per 100,000 population, presenting with one or more of the following seven chronic conditions: angina, asthma, chronic obstructive pulmonary disease (COPD), diabetes, epilepsy, heart failure and pulmonary edema, and hypertension.

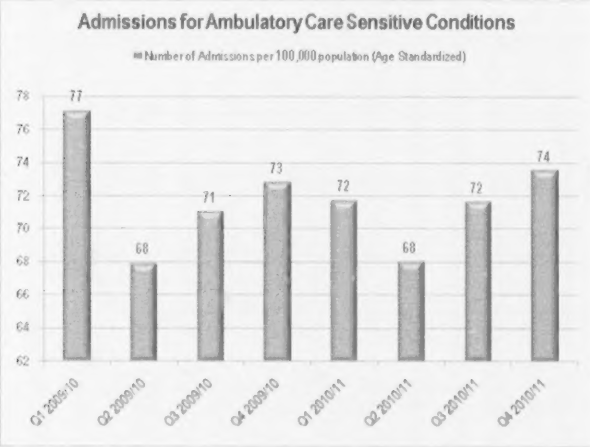
Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

Hospitalization of a person with an ACSC is considered a measure of access to primary health care services. A disproportionately high ACSC rate is presumed to reflect problems accessing appropriate care in the community. It is assumed that appropriate care could prevent the onset of this type of illness or condition, control an acute illness or condition, or manage a chronic disease or condition, preventing an avoidable admission to an acute care facility.

WHAT IS THE TARGET?

An annual target of 304 (76 per quarter) ACSC admissions per 100,000 population under age 75 years, has been established for 2010/11. As large variations exist in the rate of hospitalization for these conditions across Canada, the "right" target is not yet known (CIHI Health Indicators 2009).



Source: AHS Discharge Abstract Database

HOW ARE WE DOING?

While there has been a slight increase in overall ACSC admissions in the most recent quarter, performance remains better than target. The annual ACSC rate for the 2010/11 fiscal year is 281 per 100,000 of population under age 75 years.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A business case has been submitted for additional staffing support within the South, Central and North Zones (where targets are not being met) to enhance self-management supports and patient participation in community based programming. As well, a provincial Diabetes Working Group was established in early 2011 to identify care gaps, prioritize opportunities and establish short-term action plans for improvement.

Subsequent actions planned: AHS and Patient Care Networks (PCNs) continue to work on decreasing hospital admissions by focusing on chronic disease management and prevention, maximizing the use of inter-professional teams (e.g. social workers and mental health providers), and also ensuring that hospital flow and transitions with the community are appropriate. Also, a provincial case management model will be developed for patients with chronic disease (initial focus on diabetes and obesity).

WHAT ELSE DO WE KNOW?

Participation from PCNs in provincial quality improvement programs is expected to reduce wait times and increase access to primary care.

Information is available by zone.

HOW DO WE COMPARE?

Using a similar definition, Alberta ranked third among the 10 provinces for lowest admissions for ambulatory care sensitive conditions. Alberta = 308, Best Performing Province = 279 (British Columbia), Canada = 320 (CIHI 2008/09)

TIP # 1

Performance Measure Update

Family Practice Sensitive Conditions

Data updated quarterly.
Most current data is Q4 2010/11
Next data update expected for Q1 2011/12

△ **PERFORMANCE STATUS**

Performance is outside acceptable range, take action and monitor progress.

Baseline 2008/09: 28%

2010/11 TARGET: 27%
of ED/UCC visits
Q4 TARGET: 27%

Q4 ACTUAL: 28.0%
of ED/UCC visits

WHAT IS BEING MEASURED?

Family practice sensitive conditions report the per cent of emergency department (ED) and urgent care visits for health conditions that may be appropriately managed at a family physician's office. Examples of included conditions are: conjunctivitis and migraine. See the detailed indicator definition (currently pending approval) for full list of included conditions.

Detailed indicator definition is available.

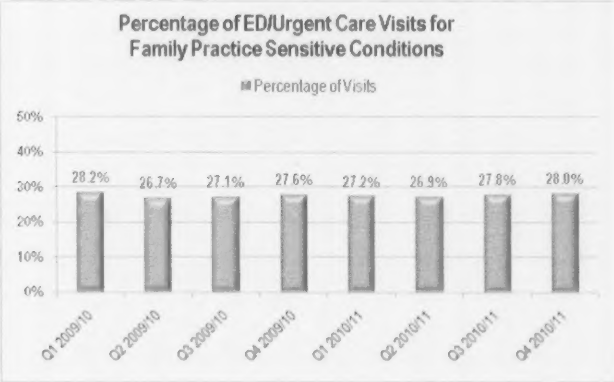
Further information on this indicator is available from the Health Quality Council of Alberta (HCQA) Measuring & Monitoring for Success report.

WHY IS THIS IMPORTANT?

Treatment when appropriate at family physician offices allows for proper follow up and better patient outcomes. The expectation is that more effective provision of primary care services would result in improvement in this measure.

WHAT IS THE TARGET?

Alberta Health Services has established the target for family practice sensitive conditions at 27 per cent of ED or urgent care visits.



Source: Provincial Ambulatory (ED/Urgent Care) Abstract Data

HOW ARE WE DOING?

The percentage of family practice sensitive conditions is slightly above the AHS target of 27 per cent of ED or urgent care visits for the most recent quarter.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Work continues on a primary care model that redirects patients from Emergency to primary care, including local level plans to enhance primary care within identified communities. A pilot "train the trainer" project on system-wide case management skills has also been initiated with Home Care staff to evaluate the impact of a case management approach on: (1) improving access to the health system; (2) eliminating gaps in service when transitioning between healthcare providers; and (3) coordinating services across health sectors. In addition, a radio campaign promoting the services of HealthLink Alberta took place in the Fall and Winter months.

Subsequent actions planned: Developments on the system-wide case management model will continue over the long-term, as will collaborations with Patient Care Networks to balance after-hours service delivery with physician recruitment and retention. In addition, a provincial public education campaign on Urgent Care services will be developed.

WHAT ELSE DO WE KNOW?

This indicator may be affected by access and continuity of primary care. See indicator: Albertans Enrolled in a Primary Care Network. Also see: Admissions for Ambulatory Care Sensitive Conditions.

Information is available by zone.

HOW DO WE COMPARE?

National benchmark comparisons are not available.

Alberta Health Services

Performance Measure Update

Health Link Alberta Service Level (% answered within 2 minutes)

Data updated quarterly.
Most current data is Q4 2010/11.
Next data update expected for Q1 2011/12.

WHAT IS BEING MEASURED?

Health Link Alberta Service Level measures the percentage of calls to Health Link Alberta that are answered within two minutes.

WHY IS THIS IMPORTANT?

One of Health Link Alberta's goals is to help people make informed decisions about their health situation and about the care that is appropriate for their symptoms. Slow response times would discourage some callers.

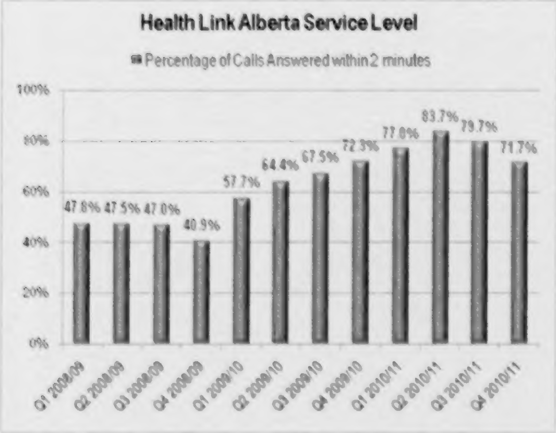
Detailed indicator definition is available.

WHAT IS THE TARGET?

Alberta Health Services (AHS) has established a 2010/11 annual target of 80 per cent of calls to be answered within two minutes.

HOW ARE WE DOING?

The percentage of Health Link Alberta calls answered within two minutes was 71.7 per cent for Q4 2010/11.



Source: Health Link Alberta, Nortel Contact Centre Management 6.0

● **PERFORMANCE STATUS**

Performance is outside acceptable range, take action and monitor progress.
Baseline 2009/10: 65%

2010/11 TARGET: 80%
Q4 TARGET: 80 %

Q4 ACTUAL: 71.7%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A review of the volume and types of calls placed to Health Link Alberta was completed. As a result, a new schedule for Nursing and Information & Referral has been implemented to better match call presentation patterns. A radio campaign promoting the services of Health Link Alberta took place in the Fall and Winter months. As well, e-mail distributions to new parents were initiated with over 14,000 new subscribers signed up year to date.

Subsequent actions planned: A plan for technology upgrades continues its development to assist with improving the Health Link Alberta wait time target. As well, a comprehensive Five-year plan for Health Link Alberta will be developed in 2011.

WHAT ELSE DO WE KNOW?

Historically, callers perceive the wait time as very good to excellent when the targeted average of two minutes is met.

HOW DO WE COMPARE?

National benchmark comparisons are not available.

Performance Measure Update

Data updated quarterly.
Most current data is Q4 2010/11.
Next data update expected for Q1 2011/12.

Children Receiving Community Mental Health Treatment within 30 Days (%)

PERFORMANCE STATUS

Performance is within acceptable range, monitor and take action as appropriate.

2010/11 TARGET: 85%
Q4 TARGET: 85%

Q4 ACTUAL: 79%

WHAT IS BEING MEASURED?

The percentage of children receiving community mental health treatment within 30 days measures the per cent of children under the age of 18 referred for mental health services who received face-to-face assessment with a mental health therapist within a 30 day period.

The data includes all scheduled, urgent and emergent cases and is limited to children enrolled in programs at community mental health clinics across Alberta.

These results exclude some enrolments that have not been completed within the selected time period.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

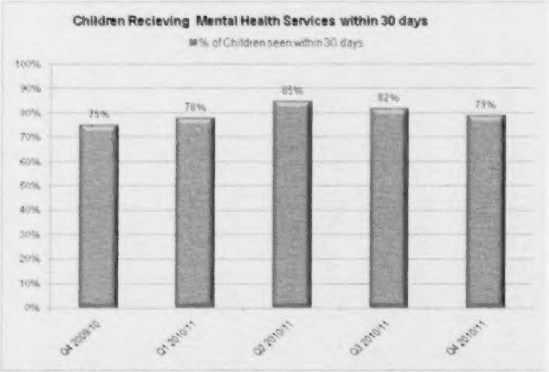
Wait times for access to community mental health treatment services are used as an indicator of patient access to the health care system and reflect the efficient use of resources.

WHAT IS THE TARGET?

The 2010/11 target for children receiving community mental health treatment within 30 days is 85 per cent. Provincial wait-time standards reflect the maximum time children should wait to receive mental health services in Alberta.

HOW ARE WE DOING?

Currently, AHS is not meeting the 85 per cent target of referred children receiving a face-to-face assessment within 30 days. Results are anticipated to improve with the implementation of subsequent years of the Children's Mental Health Plan for Alberta: Three-Year Action Plan (2008/11).



Source: AHS Mental Health Services

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Efforts have been focused at those sites which remain below target. Specific examples include:

- Implementation of coordinated regional intake and redevelopment of intake processes to ensure screening assessments take place within 2-3 working days (Edmonton).
- Increase in mental health therapy positions to reduce wait times (Edmonton and North Zones).
- Installation of a triage nurse in the Pediatric Behavioural Developmental Clinic to streamline referrals to the appropriate discipline (Calgary).
- Change in business processes to reduce the time between receipt of referral and assignment to the receiving clinic (Calgary).

Subsequent actions planned: Again, efforts are being focused at those sites which remain below target. Specific examples include:

- Improve processes to follow-up with clients who do not attend initial appointments (Edmonton).
- Complete recruitment of vacant mental health therapist positions (Edmonton and North Zones).
- Launch pilot project to allow patients/families to access discipline specific assessments as early in the care continuum as possible to prevent the need for more intensive services (Calgary).

WHAT ELSE DO WE KNOW?

There appears to be some seasonal and geographic variation in the results reported for this measure. Further analysis may inform these differences.

Information is available by zone.

HOW DO WE COMPARE?

Currently, Alberta is the only province with access standards for children's mental health, as such, there is no comparable information from other provinces regarding the wait times for children to receive community mental health treatment.

Alberta Health Services

Performance Measure Update

Coronary Artery Bypass Graft (CABG) Wait Time for Urgent Category (Urgency Level I)

Data updated quarterly.
Most current data is Q4 2010/11.
Next data update expected for Q1 2011/12

● **PERFORMANCE STATUS**

Performance is outside acceptable range, take action and monitor progress.
Baseline 2009/10: 2.4 weeks

2010/11 TARGET: 1.5
Q4 TARGET: 1.5 weeks

Q4 ACTUAL: 2.2 weeks

WHAT IS BEING MEASURED?

Coronary artery bypass graft (CABG) wait time is calculated as the time from the date of cardiac catheterization to the date surgery was completed. If a cardiac catheterization was not performed, the wait time is calculated from the date of alternate imaging, or from the date of cardiology referral to surgery.

Only scheduled CABG surgeries on adults 18 years of age and older are included in this measure; emergency procedures are not included. Urgency levels for patients are determined during peer-reviewed physician rounds in Edmonton, and by guidelines reviewed by surgeons in Calgary. Patients whose urgency level changed are excluded.

The 90th percentile is the time it takes in weeks for 90 per cent of patients to have had their surgery. Median wait time is the point at which 50 per cent of patients have had their surgery.

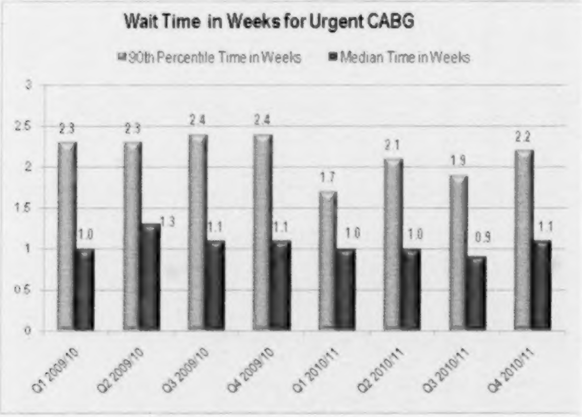
Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources.

WHAT IS THE TARGET?

The provincial/territorial benchmark for Urgency I CABG surgeries is within two weeks. The AHS target for 2010/11 is one and a half weeks for Urgent CABG surgeries.



Source: AHS Open Heart Waitlist Database (Edmonton), VELOS, APPROACH and OR data from ORIS (Calgary)

HOW ARE WE DOING?

The wait time for urgent CABG surgery is longer than the previous three quarters and remains longer than target.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A computerized "flagging" system was implemented to identify patients who are close to exceeding the allowable wait time in their applicable urgency category. A clinical assessment is then made to ensure patient safety. As well, a process was implemented for daily triage of urgent and semi-urgent cases based on patient needs and operating room availability.

Subsequent actions planned: A three-year plan for cardiac surgery to meet AHS targets will be completed by Fall 2011. Both Calgary and Edmonton are working on refining the booking process and continuing with a central intake/wait list for urgent and semi-urgent patients. As well, we are refining the development and implementation of a process to increase surgeon awareness of patients on the waiting list and length of time waiting- alerts for patients nearing access benchmarks. In this process we are ensuring that patients requiring other types of cardiovascular surgeries are not impacted.

WHAT ELSE DO WE KNOW?

All patient conditions are carefully reviewed to ensure patients are assigned a wait time that matches the seriousness of their condition. Patients are given an earlier date should their condition change while awaiting their previously assigned surgical date.

Information is available for sites performing this surgery.

HOW DO WE COMPARE?

Relevant national comparisons will be included when available. Currently work is being undertaken to establish comparable interprovincial definitions.

Alberta Health Services

Performance Measure Update

Data updated quarterly.
Most current data is Q4 2010/11.
Next data update expected for Q1 2011/12

Coronary Artery Bypass Graft (CABG) Wait Time for Semi-Urgent Category (Urgency II)

● **PERFORMANCE STATUS**

Performance is outside acceptable range, take action and monitor progress.
Baseline 2009/10: 7 weeks

2010/11 TARGET: 5.0
Q4 TARGET: 5.0 weeks

Q4 ACTUAL: 9.6 weeks

WHAT IS BEING MEASURED?

Coronary artery bypass graft (CABG) wait time is calculated as the time from the date of cardiac catheterization to the date surgery was completed. If a cardiac catheterization was not performed, the wait time is calculated from the date of alternate imaging, or from the date of cardiology referral to surgery.

Only scheduled CABG surgeries on adults 18 years of age and older are included in this measure; emergency procedures are not included. Urgency levels for patients are determined during peer-reviewed physician rounds in Edmonton, and by guidelines reviewed by surgeons in Calgary. Patients whose urgency level changed are excluded.

The 90th percentile is the time it takes in weeks for 90 per cent of patients to have had their surgery. Median wait time is the point at which 50 per cent of patients have had their surgery.

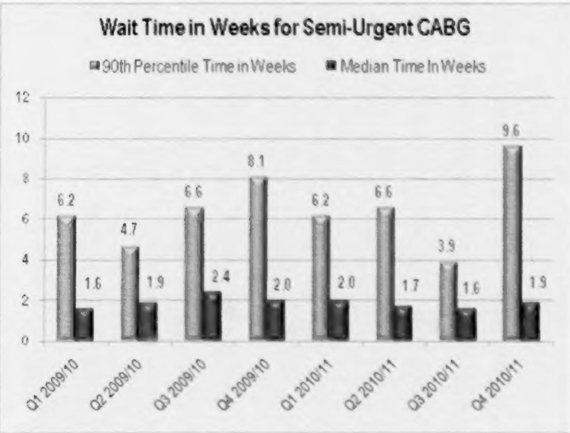
Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources.

WHAT IS THE TARGET?

The provincial/territorial benchmark for Urgency II CABG surgeries is within six weeks. The Alberta Health Services (AHS) target for 2010/11 is five weeks for semi-urgent CABG surgeries.



Source: AHS Open Heart Waitlist Database (Edmonton),
VELOS, APPROACH and OR data from ORIS, the OR database (Calgary)

HOW ARE WE DOING?

While the median wait time for semi-urgent CABG surgery has remained consistent, Q4 saw a large increase in 90th percentile wait time which is attributed to longer waits for a small group of patients (as the lowest volume category, this group can be susceptible to large swings in performance).

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A computerized "flagging" system was implemented to identify patients who are close to exceeding the allowable wait time in their applicable urgency category. A clinical assessment is then made to ensure patient safety. As well, a process was implemented for daily triage of urgent and semi-urgent cases based on patient needs and operating room availability.

Subsequent actions planned: A three-year plan for cardiac surgery to meet AHS targets will be completed by Fall 2011. Both Calgary and Edmonton are working on refining the booking process and continuing with a central intake/wait list for urgent and semi-urgent patients. As well, we are refining the development and implementation of a process to increase surgeon awareness of patients on the waiting list and length of time waiting- alerts for patients nearing access benchmarks. In this process we are ensuring that patients requiring other types of cardiovascular surgeries are not impacted.

WHAT ELSE DO WE KNOW?

All patient conditions are carefully reviewed to ensure that patients are assigned a wait time that matches the seriousness of their condition. Patients are given an earlier date if their condition changes while awaiting the previously assigned surgical date.

Information is available for sites performing this surgery.

HOW DO WE COMPARE?

Relevant national comparisons will be included when available. Currently work is being undertaken to establish comparable interprovincial definitions.

Performance Measure Update

Coronary Artery Bypass Graft (CABG) Wait Time for Scheduled Category (Urgency III)

PERFORMANCE STATUS

Performance is outside acceptable range, take action and monitor progress.
Baseline 2009/10: 31 weeks

20010/11 TARGET:
15 .0
Q4 TARGET: 15.0

Q4 ACTUAL:
19.9 weeks

Data updated quarterly.
Most current data is Q4 2010/11
Next data update expected for Q1 2011/12

WHAT IS BEING MEASURED?

Coronary artery bypass graft (CABG) wait time is calculated as the time from the date of cardiac catheterization to the date surgery was completed. If a cardiac catheterization was not performed, the wait time is calculated from the date of alternate imaging, or from the date of cardiology referral to surgery.

Only scheduled CABG surgeries on adults 18 years of age and older are included in this measure; emergency procedures are not included. Urgency levels for patients are determined during peer-reviewed physician rounds in Edmonton, and by guidelines reviewed by surgeons in Calgary. Patients whose urgency level changed are excluded.

The 90th percentile is the time it takes in weeks for 90 per cent of patients to have had their surgery. Median wait time is the point at which 50 per cent of patients have had their surgery.

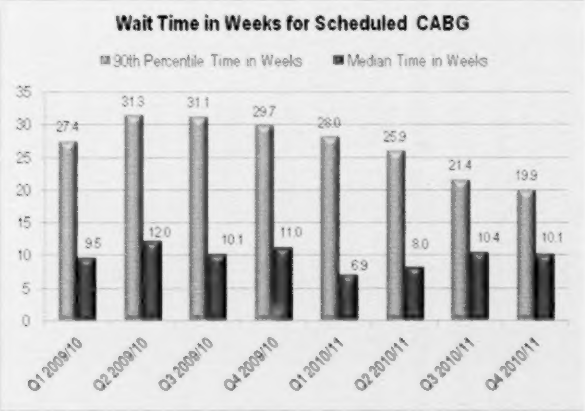
Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources.

WHAT IS THE TARGET?

The provincial/territorial benchmark for Urgency III CABG surgeries is within 26 weeks. The 2010/11 Alberta Health Services (AHS) target is 15 weeks.



Source: AHS Open Heart Waitlist Database (Edmonton),
VELOS, APPROACH and OR data from ORIS, the OR database (Calgary)

HOW ARE WE DOING?

Although the wait time for scheduled CABG surgery has improved over the last year, it is still significantly longer than target.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A computerized "flagging" system was implemented to identify patients who are close to exceeding the allowable wait time in their applicable urgency category. A clinical assessment is then made to ensure patient safety.

Subsequent actions planned: In addition to the actions noted for urgent/semi-urgent patients, Edmonton is beginning a Cardiovascular Process Improvement project planned to review each part of the patient journey. In Calgary, the referral and triage process for non-urgent patients will be re-engineered to reduce wait times. Both cities are examining existing OR capacity and efficiencies.

WHAT ELSE DO WE KNOW?

All patient conditions are carefully reviewed to ensure that patients are assigned a wait time that matches the seriousness of their condition. Patients are given an earlier date should their condition change while they are awaiting their previously assigned surgical date.

Information is available for sites performing this surgery.

HOW DO WE COMPARE?

Relevant national comparisons will be included when available. Currently work is being undertaken to establish comparable interprovincial definitions.

Performance Measure Update

Hip Replacement Wait Time

Data updated quarterly.
Most current data is Q4 2010/11.
Next data update expected for Q1 2011/12

WHAT IS BEING MEASURED?

Hip replacement wait time is the time from the date the patient and clinician agreed to hip replacement (arthroplasty) surgery as the treatment option of choice, to the date surgery was completed. Only scheduled, elective hip replacements are included in this measure. Emergency cases are not included in the calculation. The 90th percentile is the time it takes in weeks for 90 per cent of patients to have had their surgery.

Detailed indicator definition is available. Definition will be revised for future reporting.

WHY IS THIS IMPORTANT?

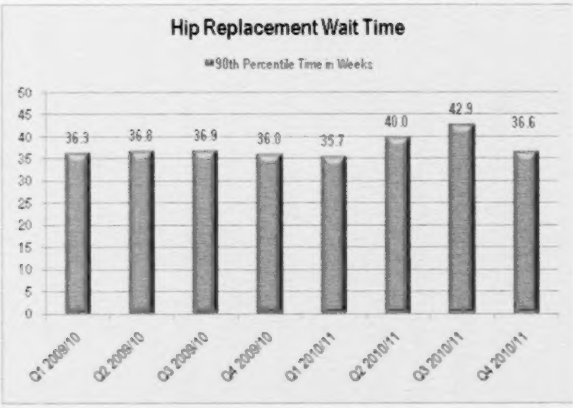
Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources.

WHAT IS THE TARGET?

The provincial/territorial benchmark for hip replacement surgeries is within 26 weeks. The Alberta target for 2010/11 is 28 weeks.

HOW ARE WE DOING?

The wait time for hip replacement surgery is significantly longer than the target. As there is variation across the province in how definitions of urgency are applied and data is collected, the actual wait time may be less than reported. Alberta Health Services (AHS) is developing standard definitions for measurement of wait times, to improve the accuracy of the measure for future reports.



Source: AHS, *DIMR from Site Surgery Wait List and Surgical Databases*

● **PERFORMANCE STATUS**

Performance is outside acceptable range, take action and monitor progress.
Baseline 2009/10: 37.1 weeks

2010/11 TARGET: 28.0
Q4 TARGET: 28.0 weeks

Q4 ACTUAL: 36.6 weeks

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A new central intake process has been established in all five zones. A new 56 bed, four operating room orthopedic surgery centre was opened in Edmonton. The provincial Hip and Knee Replacement Transformational Improvement Program (TIP) continues with a view to reducing wait times and length of stay. A provincial plan to achieve the 14 week wait time targets by 2014/15 for hip and knee replacement has been developed.

Subsequent actions planned: Funding for year one of the five-year provincial hip and knee replacement plan will increase knee replacement volumes starting in Summer 2011, once staff/physician resources are in place. These increased volumes, along with ongoing improvement work to eliminate inefficient processes and use of inpatient and sub-acute bed days, will help to achieve wait time targets. Variation in central intake processes across the province will also be addressed. As well, better linkage of primary health care providers to medical and surgical specialists will occur through a standardized approach for assessing, referring and booking patients with specialists (cancer, cardiac, hip/knee, and cataract), to be developed by early 2012.

WHAT ELSE DO WE KNOW?

Currently this measure reports on the wait time from decision date to surgical date. Provincial wait time definitions from primary care referral to surgical date have been approved by the Bone & Joint Clinical Network, for implementation across the Province.

Information is available by site.

HOW DO WE COMPARE?

Using a similar measure in 2010, Alberta ranked sixth among the 10 provinces for hip replacement surgery wait times. Alberta = 38.3 weeks, Best Performing Province = 24.6 weeks (Ontario) (CIHI, 2010)

Performance Measure Update

Knee Replacement Wait Time

Data updated quarterly.
Most current data is Q4 2010/11.
Next data update expected for Q1 2011/12

WHAT IS BEING MEASURED?

Knee replacement wait time is the time from the date the patient and clinician agreed to knee replacement (arthroplasty) surgery as the treatment option of choice, to the date surgery was completed.

Only scheduled, elective knee replacements are included in this measure. Emergency cases are not included in the calculation.

The 90th percentile is the time it takes in weeks for 90 per cent of patients to have had their surgery.

Detailed indicator definition is available. Definition will be revised for future reporting.

WHY IS THIS IMPORTANT?

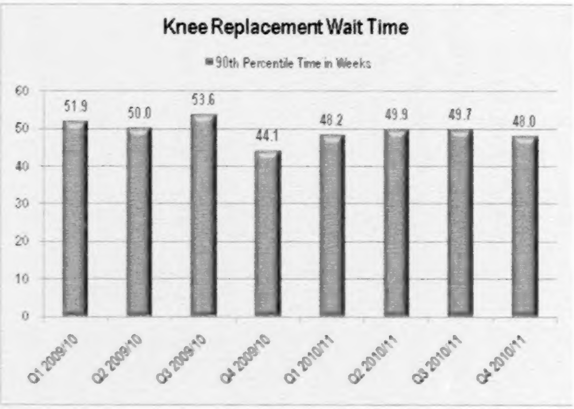
Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources.

WHAT IS THE TARGET?

The provincial/territorial benchmark for knee replacement surgeries is within 26 weeks. The Alberta target for 2010/11 is 42 weeks.

HOW ARE WE DOING?

The wait time for knee replacement surgery is longer than the target. As there is variation across the province in how definitions of urgency are applied and data is collected, the actual wait time may be less than reported. Alberta Health Services (AHS) is developing standard definitions for measurement of wait times, to improve the accuracy of the measure for future reports.



Source: AHS, DIMR from Site Surgery Wait List and Surgical Databases

● PERFORMANCE STATUS

Performance is outside acceptable range, take action and monitor progress.
Baseline 2009/10: 51.1 weeks

2010/11 TARGET: 42.0
Q4 TARGET: 42.0 weeks

Q4 ACTUAL: 48.0 weeks

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A new central intake process has been established in all five zones. A new 56 bed, four operating room orthopedic surgery centre was opened in Edmonton. The provincial Hip and Knee Replacement Transformational Improvement Program (TIP) continues with a view to reducing wait times and length of stay. A provincial plan to achieve the 14 week wait time targets by 2014/15 for hip and knee replacement has been developed.

Subsequent actions planned: Funding for year one of the five-year provincial hip and knee replacement plan will increase knee replacement volumes starting in Summer 2011, once staff/physician resources are in place. These increased volumes, along with ongoing TIP work to eliminate inefficient processes and use of inpatient and sub-acute bed days, will help to achieve wait time targets. Variation in central intake processes across the province will also be addressed. As well, better linkage of primary health care providers to medical and surgical specialists will occur through a standardized approach for assessing, referring and booking patients with specialists (cancer, cardiac, hip/knee, and cataract), to be developed by early 2012.

WHAT ELSE DO WE KNOW?

Currently this measure reports on the wait time from decision date to surgical date, Provincial waiting time definitions from primary care referral to surgical date have been approved by the Bone & Joint Clinical Network for implementation across the Province.

Information is available by site.

HOW DO WE COMPARE?

Using a similar measure in 2010, Alberta ranked sixth among the 10 provinces for knee replacement surgery wait times. Alberta = 49.1 weeks, Best Performing Province = 27.1 weeks (Ontario) (CIHI, 2010)

Performance Measure Update

Cataract Surgery Wait Time

Data updated quarterly.
Most current data is Q4 2010/11.
Next data update expected for Q1 2011/12.

WHAT IS BEING MEASURED?

Cataract surgery wait time is defined as the time from the date when the patient and clinician agreed to cataract surgery as the treatment option of choice, to the date the surgery was completed.

Only the first eye cataract surgery is included in the measure. Patients who voluntarily delayed their procedure, those who had a scheduled follow-up procedure, and those that received emergency care are excluded from the measure. Calgary cataract wait times include patients who voluntarily delay their procedure.

The 90th percentile is the time it takes in weeks for 90 per cent of patients to have had their surgery.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

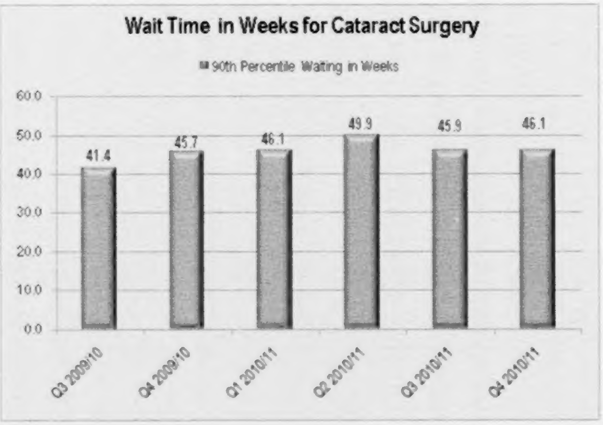
Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources.

WHAT IS THE TARGET?

The provincial/territorial benchmark for high risk cataract surgeries is within 16 weeks. The Alberta target for 2010/11 is 36 weeks.

HOW ARE WE DOING?

The preliminary result for 90th percentile wait time for Cataract Surgery for Q4 2010/11 was 46.1 weeks which exceeds the target time of 36 weeks.



Source: Alberta Health & Wellness

● **PERFORMANCE STATUS**

Performance is outside acceptable range, take action and monitor progress.
Baseline 2009/10: 41 weeks

2010/11 TARGET:
36 weeks
Q4 TARGET: 36.0

Q4 ACTUAL:
46.1 weeks

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Cataract volumes for the 2010/11 year increased to 12,180 in Calgary and 13,961 in Edmonton, an increase of 2,889 and 2,136 cases from the previous year, respectively. Of all the Zones, Calgary continues to have the highest backlog of cases, yet this was reduced from 9,500 people waiting in October 2010 to 6,050 people waiting in April, 2011. As well, the average wait time in Calgary also decreased from 28 (April 2010) to 24 weeks (April 2011).

Subsequent actions planned: Contract extensions with non-hospital surgical facilities in Edmonton and Calgary have been negotiated. Calgary and Edmonton cataract activity will continue into the 2011/12 fiscal year with increased volumes allocated as in 2010/11. In addition, a 3-year plan for meeting long-term wait time targets is scheduled for completion in Fall 2011.

Plans are underway to manage the waitlist by ensuring that all patients who need to be waitlisted are.

WHAT ELSE DO WE KNOW?

Cataract surgery wait times are significantly longer in Calgary than elsewhere within the province.

Information is available by zone.

HOW DO WE COMPARE?

Using a similar measure, Alberta ranked 10th among the 10 provinces for cataract surgery wait times. Alberta = 47.3 weeks, Best Performing Province = 17.0 weeks (New Brunswick) (CIHI, 2010)

Alberta Health Services

TIP #2

Performance Measure Update

Other Scheduled Surgery Wait Time

Data updated quarterly.
Most current data is Q4 2010/11.
Next data update expected for Q1 2011/12.

WHAT IS BEING MEASURED?

Wait time for other scheduled surgery is defined as the time from the date when the patient and clinician agreed to surgery as the treatment option of choice, to the date the surgery was completed.

Only scheduled surgeries are included in this measure. Patients who voluntarily delayed their procedure, those who had a scheduled follow-up procedure, and those that received emergency care are excluded from the measure.

All other scheduled surgeries exclude Coronary Artery Bypass Graft (CABG), hip replacement, knee replacement and cataract surgeries.

The 90th percentile is the time it takes in weeks for 90 per cent of patients to have had their surgery.

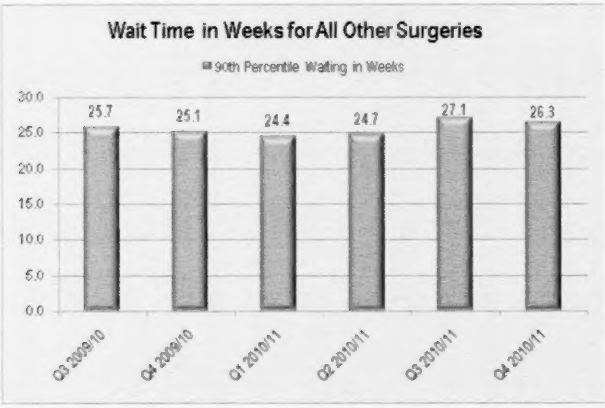
Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources.

WHAT IS THE TARGET?

No wait time target for other scheduled surgeries has been defined for 2010/11. Targets will be set in 2011/12.



Source: Alberta Health & Wellness

Note: Q3 2010/11 figures include incomplete contracted surgical facilities data; figures will be revised as data becomes available.

PERFORMANCE STATUS

Performance target for 2010/11 is not yet established for comparison.

2010/11 TARGET: TBD

Q4 ACTUAL: 26.3 weeks

HOW ARE WE DOING?

Using latest developed measurement methodology (under review) 90th percentile wait times for other surgeries was 26.3 weeks for Q4 2010/11.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Wait time targets for cancer surgery have been developed. As well, a Surgical Services Health Plan Working Group (SSHPWG) was established to develop a coordinated and comprehensive set of projects that will deliver a sustainable surgical service delivery model for Albertans.

Subsequent actions planned: New surgical volume investments will be made for spinal implants, cancer surgery and other general surgeries. The SSHPWG will complete a comprehensive plan by Fall 2011 to: (1) measure and manage wait times from referral to discharge; (2) maintain and improve patient outcomes in line with industry best practice; and (3) establish provincial surgical efficiency targets (e.g. on time starts, turnaround times, percent overruns, etc.). In addition, a plan to further implement a Safe Surgery Checklist in all operating rooms across Alberta will be developed by Fall 2011.

WHAT ELSE DO WE KNOW?

Information is available by zone.

HOW DO WE COMPARE?

National benchmark comparisons are not available.

Performance Measure Update

Radiation Therapy Wait Time Referral to First Consultation (Radiation Oncologist)

Data updated quarterly.
Most current data is Q4 2010/11.
Next data update expected for Q1 2011/12.

WHAT IS BEING MEASURED?

Referral to consultation by radiation oncologist wait time is the time from the date that a referral was received from a physician outside a cancer facility to the date that the first consult with a radiation oncologist occurred.

Currently this data is collected on patients referred to a tertiary cancer facility (Cross Cancer Institute in Edmonton, Tom Baker Cancer Centre or Holy Cross in Calgary). As of Q3 2010/11, data is also reported on patients referred to Jack Ady Cancer Centre in Lethbridge. There is a project underway to collect these data at three additional cancer centres that provide consultations to patients in Medicine Hat, Red Deer, and Grande Prairie.

The 90th percentile is the time it takes in weeks for 90 per cent of patients to have had their first consult.

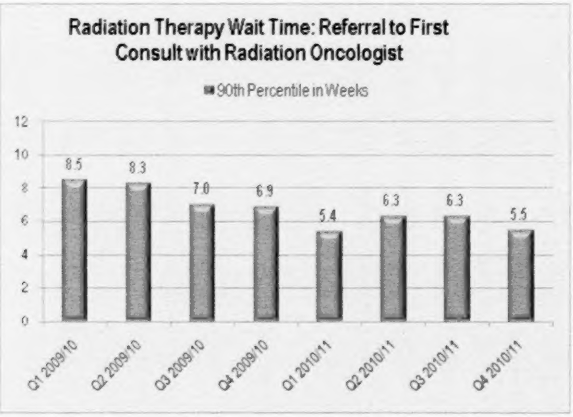
Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

Wait times are an important measure of how quickly people are getting access to cancer care. They reflect the ability of Alberta Health Services (AHS) to meet the needs of cancer patients.

WHAT IS THE TARGET?

The Alberta target for referral to radiation oncologist consultation is four weeks for 90 per cent of patients.



Source: EBI-2009-009 – Timeliness of care – referral to first consult by consult type and facility

Note: Jack Ady Cancer Centre (Lethbridge) data is included as of Q3 2010/11.

● **PERFORMANCE STATUS**

Performance is outside acceptable range, take action and monitor progress.

Baseline 2009/10: 7.4 weeks

2010/11 TARGET: 4
Q4 TARGET: 4 weeks

Q4 Actual: 5.5 weeks

HOW ARE WE DOING?

Wait times from cancer referral to consultation by radiation oncologists are outside the target. However, in the majority of tumour groups, patients are seen within the target timeline. The wait time is 5.5 weeks in Q4 2010/11.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: The First Contact program teams have been established at both the Tom Baker Cancer Centre (four tumour groups) and the Cross Cancer Institute (two tumour groups). This enables new patients to be contacted within 48 hours and given appointment dates. In addition, a Radiation Therapy Wait Time plan has been designed to meet the four-week target by the end of the 2011/12 year, consisting of: (1) improvements in referral management; (2) re-engineering of clinical scheduling processes; and (3) a strategic frontline staff adjustment.

Subsequent actions planned: Subject to approval, implementation of the Radiation Therapy Wait Time plan is scheduled to begin in Summer 2011. As well, implementation will continue on rolling out the First Contact program to all sites and for all tumour groups by the end of 2012/13.

WHAT ELSE DO WE KNOW?

Sometimes referrals are missing important medical information cancer specialists require before they meet with the patient. This causes delays. We are working with referring physicians to improve this situation.

Information is available by site.

HOW DO WE COMPARE?

National benchmark comparisons are not currently available but are under development. Ontario targets 14 days from the time between a referral to a specialist to the time of consult with the patient. Current trends indicate that 60 to 75 per cent of patients are seen within this target (Cancer Care Ontario, 2010).

Performance Measure Update

Data updated quarterly.
Most current data is Q4 2010/11.
Next data update expected for Q1 2011/12.

Radiation Therapy Wait Time
Ready-to-Treat to First Radiation Therapy

■ **PERFORMANCE STATUS**

Performance is at or better than target, continue to monitor.
Baseline 2009/10: 5.4 weeks

2010/11 TARGET: 4
Q4 TARGET: 4 weeks

Q4 ACTUAL: 3.7weeks

WHAT IS BEING MEASURED?

Ready-to-treat to first radiation therapy wait time is the time from the date the patient was physically ready to commence treatment to the date that the patient received his/her first radiation therapy.

Currently this data is reported on patients who receive radiation therapy at the Cross Cancer Institute in Edmonton, the Tom Baker Cancer Centre in Calgary, and the Jack Ady Cancer Centre in Lethbridge. The data apply only to patients receiving external beam radiation therapy (i.e. brachytherapy is not included).

The 90th percentile is the time it takes in weeks for 90 per cent of patients to have had their first treatment after being assessed as ready for treatment.

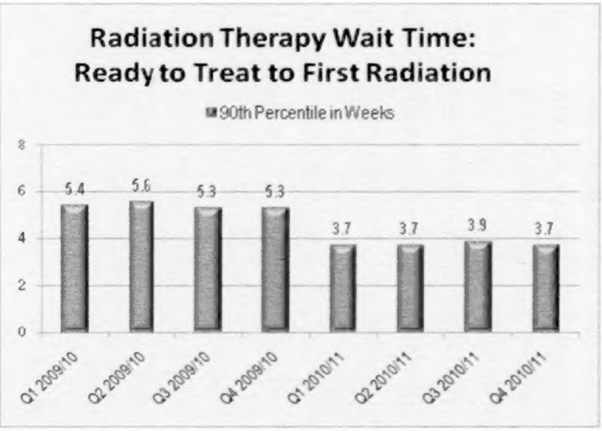
Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

Wait times are an important measure of how quickly people are getting access to cancer care. They reflect the ability of Alberta Health Services (AHS) to meet the needs of cancer patients.

WHAT IS THE TARGET?

The provincial/territorial benchmark for radiation treatment is that patients will receive the first treatment within four weeks (28 days) of being ready to treat. The Alberta target is four weeks.



Source: EBI -2009-002 Radiation Therapy Time From Ready to Treat to First Radiation Treatment by Institution

Note: Jack Ady Cancer Centre (Lethbridge) data is included as of Q3 2010/11.

HOW ARE WE DOING?

The proportion of patients receiving radiation therapy within the expected time period is better than the target. Significant improvement has occurred since Q4 2009/10. The Q4 2010/11 90th percentile time was 3.7 weeks.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: The Jack Ady Cancer Centre in Lethbridge is now fully operational and to March 31, 2011 has delivered almost 250 courses of radiation therapy to patients since opening. All three sites are currently performing better than target.

Subsequent actions planned: Performance at all sites will continue to be monitored and action plans established in the event targets are not being met. Expansion of tumour sites treated at the Jack Ady Cancer Centre will expand in 2011/12 to include radical lung cancer patients. Re-engineering of business processes for radiation therapy consultation will occur in Edmonton and Calgary. In addition, planning remains on track to open the Central Alberta Cancer Centre in Red Deer in 2013.

WHAT ELSE DO WE KNOW?

AHS is reviewing benchmark work done by Provincial/Territory Governments in 2005, and reported in October 2009.

Information is available by site.

HOW DO WE COMPARE?

Using a similar measure, Alberta ranked sixth among eight provinces for radiation therapy wait times. Alberta = 3.7 weeks, Best Performing Province = 2.9 weeks (Ontario and Saskatchewan) (CIHI, 2010)

Performance Measure Update

Patients Discharged from Emergency Department or Urgent Care Centre within 4 hours (%) (16 Higher Volume EDs)

Data updated quarterly.
Most current data is Q4 2010/11.
Next data update expected for Q1 2011/12

WHAT IS BEING MEASURED?

Patients discharged from an Emergency Department (ED) or Urgent Care Centre (UCC) measures the length of time from the first documented time after arrival at the ED/UCC to the time they are discharged (16 higher volume EDs). The percentage of patients discharged whose length of stay in ED/UCC is less than four hours is reported.

Patients who leave without being seen, leave against medical advice, are admitted as an inpatient to the same facility, or die before or during the ED visit, are not included in this measure.

Sites in this grouping are based on criterion of high volume or in a category of teaching, large urban and regional emergency centre. Site-specific data for all 16 facilities are listed here.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

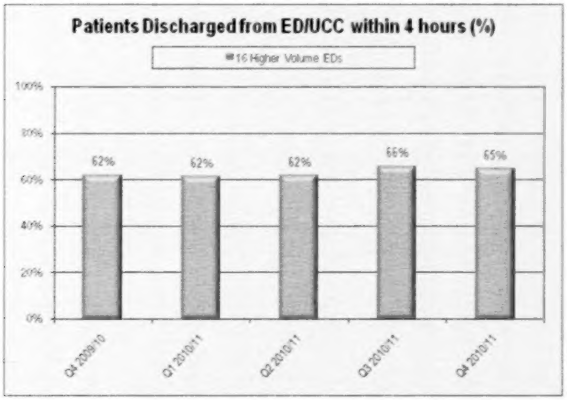
The amount of time spent waiting for treatment is a measure of access to the health care system. Patients treated in the ED/UCC should receive care in a timely fashion. Excessive wait times for care can result in treatment delays for individual patients and reduced efficiency in the flow of patients.

WHAT IS THE TARGET?

Alberta Health Services has established a 2010/11 target of 70 per cent of patients discharged within four hours for the 16 higher volume EDs.

HOW ARE WE DOING?

In Q4 2010/11, 65 per cent of patients at the 16 higher volume EDs were discharged within four hours. This is below the target.



Source: Calgary and Edmonton Emergency Department Information System Data (REDIS,EDIS) and AHS Ambulatory Care Reporting System Data (ACRS, NACRS)

△ **PERFORMANCE STATUS**

Performance is within acceptable range, monitor and take action as appropriate.
Baseline 2008/09: 62%

2010/11 TARGET: 70%
Q4 TARGET: 70%

Q4 ACTUAL: 65%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Staffing schedules at Health Link Alberta have been optimized to match call presentation patterns, a radio campaign was launched to promote the benefits of Health Link Alberta and urgent care centres, additional efforts have been focused at those sites remaining below target. Calgary Zone (Foothills Medical Centre, Rockyview General Hospital, Peter Lougheed Centre):

- Added an extra physician shift on Mondays due to high activity (Foothills)
- Revised criteria for activating the on-call ED physician to ensure a more proactive response
- Addition of the equivalent of 10 FTE's of physician support in the ED (e.g. the on-call ED physician has been accessed 70-80per cent of the time)
- Assigned a triage nurse to focus on patient flow within the ED (Foothills)
- Implemented ED physician huddles each morning
- Installed greeters in the waiting rooms to answer questions and to assist patients and families
- Increased use of transporting EMS patients to alternate destinations (i.e. Urgent Care Centers)
- Daily discharge rounds at all sites
- The use of an electronic decision support tool by nurses and doctors, MEDWORXX, to identify those patients who are ready for discharge (Foothills & Rockyview)

In the Edmonton zone (University of Alberta Hospital, Royal Alexandra Hospital, Grey Nuns Community Hospital, Misericordia Community Hospital, Sturgeon Community Hospital):

- Implementation of LEAN improvement projects to improve patient flow and access:
  - Grouping of like patients to designated ED spaces with specific physician/nurse teams and reorganization of common supplies/equipment for each patient type. Preliminary results of 18 per cent more patients discharged within target (Royal Alexandra)
  - Strategies developed to reduce specific process times; e.g. triage to bed location; to physician assessment; to consult times; to admission to ward or discharge from ED (U of A, Misericordia)

Performance Measure Update continues on next page ...

  - Improved turn-around times for lab testing (Grey Nuns, Misericordia)
- The Sturgeon facility moved into its new physical ED space; education on redesigned ED processes delivered to physicians and nurses
- Addition of Care Manager to facilitate elderly population accessing community resources (Misericordia)
- Enhanced multidisciplinary support in ED (Physiotherapy and Social Work) to identify patients that can go home with added resources (Grey Nuns)
- Increased staffing in Rapid Assessment Zone and Fast Track to improve turn-around time and thus free up treatment spaces (Grey Nuns)

Subsequent actions planned: In the Calgary zone (Foothills, Rockyview, Peter Lougheed):

- Process improvement review to reduce the time from triage to patient registration (Rockyview)
- Review feasibility of adding an extra surge shift for ED physicians on Monday/Tuesday (busiest days) (Rockyview)
- Potential relocation of Transition Services support within the ED to better manage complex discharge processes (Foothills)

In the Edmonton zone (U of A, Royal Alexandra, Grey Nuns, Misericordia, Sturgeon):

- Implementation of software using real-time information from the ED to display patient volumes, incoming EMS volumes and the severity of patient conditions across Edmonton sites (the system has been used in Calgary since 2007 and has helped to provide a window into ED workload, assist with managing existing capacity and allow EMS to return to service faster)
- Implementation of LEAN improvement project to identify and decrease obstacles to timely patient discharge from the ED (Royal Alexandra)
- Investigate with Diagnostic Imaging ability for enhanced after hours services (Sturgeon)
- Add Care Manager to facilitate elderly population accessing community resources (Grey Nuns)
- Benchmark and model efficiencies gained from the Royal Alexandra LEAN improvement project (U of A)
- Addition of 12 new treatment spaces to the Stollery Children's Hospital ED is on track for March 2012
- Complete process mapping to identify opportunities to improve patient flow from triage to admission/discharge (Stollery)

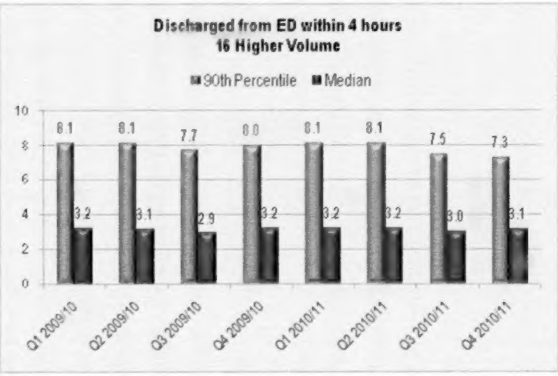
ED physicians will enhance coverage by modifying shift rotations to ensure maximum coverage during peak times (U of A, Stollery)

WHAT ELSE DO WE KNOW?

Reasons for variation of length of stay across sites include complexity of patients, capacity limitations, operational efficiency and access to other primary care options (family physicians, walk-in clinics).

Information is available by site.

Weekly ED Length of Stay (LOS) is available for a subset of sites where more timely data is readily available.



Median and 90th Percentile data are available by site.

HOW DO WE COMPARE?

Relevant national comparisons will be included as available.

Performance Measure Update

Patients Discharged from Emergency Department or Urgent Care Centre within 4 hours (%) (All Sites)

Data updated quarterly.
Most current data is Q4 2010/11.
Next data update expected for Q1 2011/12.

WHAT IS BEING MEASURED?

Patients discharged from an Emergency Department (ED) or Urgent Care Centre (UCC) measures the length of time from the first documented time after arrival at the ED/UCC to the time they are discharged (all sites). The percentage of patients discharged whose length of stay in ED/UCC is less than four hours is reported.

Patients who leave without being seen, leave against medical advice, are admitted as an inpatient to the same facility, or die before or during the ED visit, are not included in this measure.

This ED/UCC measure is presented for all sites.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

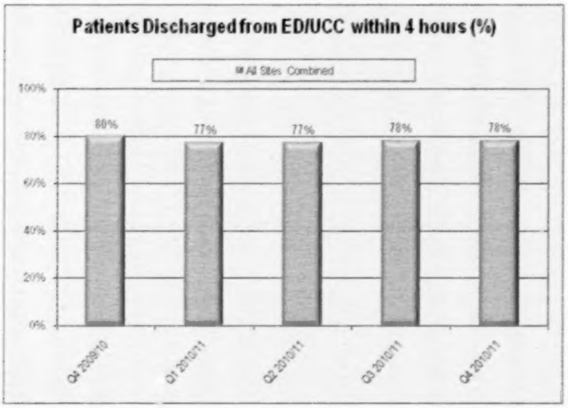
The amount of time spent waiting for treatment is a measure of access to the health care system. Patients treated in the ED/UCC should receive care in a timely fashion. Excessive wait times for care can result in treatment delays for individual patients and reduced efficiency in the flow of patients.

WHAT IS THE TARGET?

Alberta Health Services (AHS) has established a target for 2010/11 of 82 per cent of patients discharged within four hours for all sites.

HOW ARE WE DOING?

In Q4 2010/11, 78 per cent of patients presenting and subsequently discharged at ED/UCC sites within four hours.



Source: Calgary and Edmonton Emergency Department Information System Data (REDIS,EDIS) and AHS Ambulatory Care Reporting System Data (ACRS, NACRS)

PERFORMANCE STATUS

Performance is within acceptable range monitor and take action as appropriate.
Baseline 2008/09: 80%

2010/11 TARGET: 82%
Q4 TARGET: 82%

Q4 ACTUAL: 78 %

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Staffing schedules at Health Link Alberta have also been optimized to match call presentation patterns, and a radio campaign was launched to promote the benefits of Health Link Alberta and urgent care centres. Additional efforts have been focused at those sites which remain below target. Calgary zone (Foothills Medical Centre, Rockyview General Hospital, Peter Lougheed Centre):

- Added an extra physician shift on Mondays due to high activity (Foothills)
- Revised criteria for activating the on-call ED physician to ensure a more proactive response
- Addition of the equivalent of 10 FTE's of physician support in the ED (e.g. the on-call ED physician has been accessed 70-80 per cent of the time)
- Assigned a triage nurse to focus on patient flow within the ED (Foothills)
- Implemented ED physician huddles each morning
- Installed greeters in the waiting rooms to answer questions and to assist patients and families
- Increased use of transporting EMS patients to alternate destinations (i.e. Urgent Care Centers)
- Daily discharge rounds at all sites
- The use of an electronic decision support tool by nurses and doctors, MEDWORXX, to identify those patients who are ready for discharge (Foothills & Rockyview)

Edmonton zone (University of Alberta Hospital, Royal Alexandra Hospital, Grey Nuns Community Hospital, Misericordia Community Hospital, Sturgeon Community Hospital):

- Implementation of LEAN improvement projects to improve patient flow and access:
  - Grouping of like patients to designated ED spaces with specific physician/nurse teams and reorganization of common supplies/equipment for each patient type. Preliminary results of 18 per cent more patients discharged within target (Royal Alexandra)
  - Strategies developed to reduce specific process times; e.g. triage to bed location; to physician assessment; to consult times; to admission to ward or discharge from ED (U of A, Misericordia)

Performance Measure Update continues on next page ...

  - Improved turn-around times for lab testing (Grey Nuns, Misericordia)
- The Sturgeon facility moved into its new physical ED space; education on redesigned ED processes delivered to physicians and nurses
- Addition of Care Manager to facilitate elderly population accessing community resources (Misericordia)
- Enhanced multidisciplinary support in ED (Physiotherapy and Social Work) to identify patients that can go home with added resources (Grey Nuns)
- Increased staffing in Rapid Assessment Zone and Fast Track to improve turn-around time and thus free up treatment spaces (Grey Nuns)

Subsequent actions planned: Calgary zone (Foothills, Rockyview, Peter Lougheed):

- Process improvement review to reduce the time from triage to patient registration (Rockyview)
- Review feasibility of adding an extra surge shift for ED physicians on Monday/Tuesday (busiest days) (Rockyview)
- Potential relocation of Transition Services support within the ED to better manage complex discharge processes (Foothills)

Edmonton Zone (U of A, Royal Alexandra, Grey Nuns, Misericordia, Sturgeon):

- Implementation of software using real-time information from the ED to display patient volumes, incoming EMS volumes and the severity of patient conditions across Edmonton sites (the system has been used in Calgary since 2007 and has helped to provide a window into ED workload, assist with managing existing capacity and allow EMS to return to work faster)
- Implementation of LEAN improvement project to identify and decrease obstacles to timely patient discharge from the ED (Royal Alexandra)
- Investigate with Diagnostic Imaging ability for enhanced after hours services (Sturgeon)
- Add Care Manager to facilitate elderly population accessing community resources (Grey Nuns)
- Benchmark and model efficiencies gained from the Royal Alexandra LEAN improvement project (U of A)
- Addition of 12 new treatment spaces to the Stollery Children's Hospital ED is on track for March 2012
- Complete process mapping to identify opportunities to improve patient flow from triage to admission/discharge (Stollery)
- ED physicians will enhance coverage by modifying shift rotations to ensure maximum coverage during peak times (U of A, Stollery)

WHAT ELSE DO WE KNOW?

There are many reasons why ED/UCC length of stay may vary across sites, including complexity of patients, limitations (treatment spaces, staffing), operational efficiency and access to other primary care options (family physicians, walk-in clinics).

Information is available by zone and site.

Weekly ED Length of Stay (LOS) is available for a subset of sites where more timely data is readily available.

HOW DO WE COMPARE?

Relevant national comparisons will be included as available.

Alberta Health Services

TIP #2

Performance Measure Update

Patients Admitted from Emergency Department within 8 hours (%) (15 Higher Volume EDs)

Data updated quarterly.
Most current data is Q4 2010/11.
Next data update expected for Q1 2011/12.

WHAT IS BEING MEASURED?

The total time patients spend in an Emergency Department (ED) is calculated from the first documented time after arrival at emergency until the time they enter the hospital as an inpatient (15 higher volume EDs). The percentage of admitted patients whose length of stay in ED is less than eight hours is reported.

This measure does not apply to Urgent Care Centre (UCC) facilities as these facilities do not have inpatient spaces to receive admitted patients.

Sites in this grouping are based on criterion of high volume or in a category of teaching, large urban and regional emergency centre. Site-specific data for all 15 facilities are listed here.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

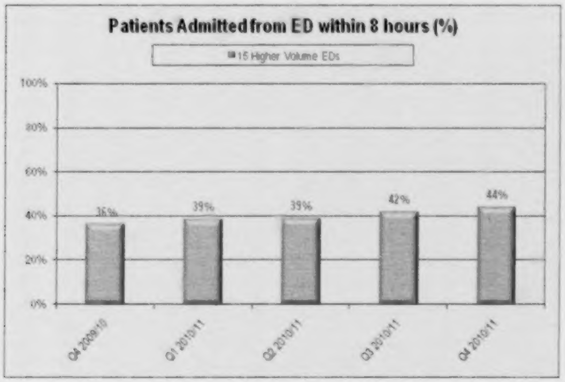
ED patients requiring hospital admission should be admitted to the appropriate inpatient environment in a timely fashion. Total time spent can be a measure of access to the health care system and a reflection of efficient use of resources.

WHAT IS THE TARGET?

Alberta Health Services (AHS) has established a target of 45 per cent of patients admitted leaving the ED within eight hours for the 15 higher volume EDs for 2010/11.

HOW ARE WE DOING?

In Q4 2010/11, 44 per cent of admitted patients at the 15 higher volume EDs left the ED within eight hours.



Source: Calgary and Edmonton Emergency Department Information System Data (REDIS,EDIS) and AHS Ambulatory Care Reporting System Data (ACRS, NACRS)

PERFORMANCE STATUS

Performance is within acceptable range of target, monitor and take action as appropriate.
Baseline 2008/09: 36%

2010/11 TARGET: 45%
Q4 TARGET: 45%

Q4 ACTUAL: 44%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A total of 323 new hospital beds have been opened in Calgary and Edmonton as of March 31, 2011 to improve patient flow. Staffing schedules at Health Link Alberta have also been optimized to match call presentation patterns, and a radio campaign was launched to promote the benefits of Health Link Alberta and urgent care centres. Additional efforts have been focused at those sites which remain below target.

Calgary Zone (Foothills Medical Centre, Rockyview General Hospital, Peter Lougheed Centre):

- Addition of the equivalent of 10 FTE's of physician support in the ED (e.g. the on-call ED physician has been accessed 70-80 per cent of the time)
- Bed huddles implemented three times a day
- Software implemented to initiate earlier discharge planning on inpatient units
- Optimization of Medical Assessment Unit (Rockyview)
- Ongoing implementation of over-capacity protocols
- Monitoring of Length of Stay data for those services that are above the national average and developing strategies and processes to reduce LOS

Edmonton Zone (University of Alberta Hospital, Royal Alexandra Hospital, Grey Nuns Community Hospital, Misericordia Community Hospital, Sturgeon Community Hospital):

- Medicine Unit Manager coverage expanded to the weekend and initiation of weekend bed huddle meetings to enhance patient movement out of ED seven days per week (Royal Alexandra)
- Expanded bed huddles with support services to develop daily plans to expedite transfer of patients to inpatient bed spaces
- Addition of a Triage Liaison Physician to facilitate timely consults, review admission issues, need for telemetry and suggest orders to ensure patients requiring admission are moved in a timely manner
- The Sturgeon facility moved into its new physical ED space; education on redesigned ED processes delivered to physicians and nurses

Performance Measure Update continues on next page

- Length of stay (LOS) task force established and LEAN training delivered to managers, directors, educators and unit supervisors to identify further opportunities for reducing LOS

Subsequent actions planned: The five-year expansion plan for additional continuing care spaces is expected to reduce ED length of stay for patients requiring admission from ED.

Calgary Zone (Foothills, Rockyview, Peter Lougheed):

- Process improvement efforts to reduce: (1) time between triage and admission process; and (2) turn-around time for inpatient bed availability
- Additional community capacity planned for Alternate Level of Care, Mental Health and Home Care
- Ongoing work with Mental Health on transition units to support transfer of mental health patients where appropriate
- Work is ongoing with Community partners to identify opportunities for decreasing the number of patients on delay for supported living

Edmonton Zone (U of A, Royal Alexandra, Grey Nuns, Misericordia, Sturgeon):

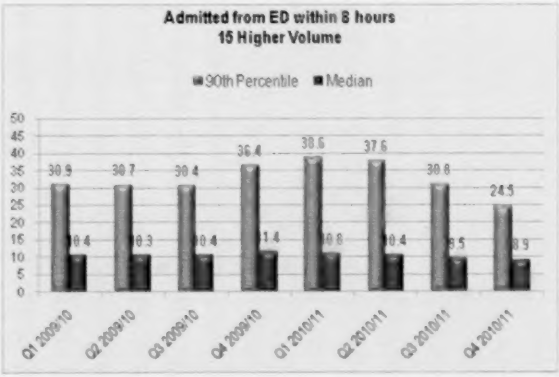
- Implementation of software using real-time information from the ED to display patient volumes, incoming EMS volumes and the severity of patient conditions across Edmonton sites (the system has been used in Calgary since 2007 and has helped to provide a window into ED workload, assist with managing existing capacity and allow EMS to return to work faster)
- Increases to the number of daily bed huddles
- Sharing of the most effective/efficient triage models across inpatient services to improve flow
- I-Care Unit to open at U of A to accommodate general internal medicine patients that require closer observation and telemetry for a further 24-48 hours (patients previously boarded in ED)
- Ongoing review of ED patients exceeding the eight hour target: examination of barriers, issues and opportunities for improvement
- Addition of 12 new treatment spaces to the Stollery Children's Hospital ED is on track for March 2012

WHAT ELSE DO WE KNOW?

Reasons for length of stay variation across sites include the complexity of patient conditions presenting to ED, capacity limitations, as well as operational efficiency. The demand for ED services can vary also significantly between sites and/or communities as a result of access to other primary care options (e.g. family physicians, walk-in clinics).

Information is available by site.

Weekly ED Length of Stay (LOS) is available for a subset of sites where more timely data is readily available.



Median and 90th Percentile data are available by site.

HOW DO WE COMPARE?

Relevant national comparisons will be included as available.

Performance Measure Update

Data updated quarterly.
Most current data is Q4 2010/11.
Next data update expected for Q1 2011/12

Patients Admitted from Emergency Department within 8 hours (%) (All Sites)

WHAT IS BEING MEASURED?

The total time patients spend in an Emergency Department (ED) is calculated from the first documented time after arrival at emergency until the time they enter the hospital as an inpatient (all sites). The percentage of admitted patients whose length of stay in ED is less than eight hours is reported.

The performance for the 15 highest volume teaching, large urban and regional ED sites as well as the average performance across all AHS sites combined is measured.

Detailed definition is available.

WHY IS THIS IMPORTANT?

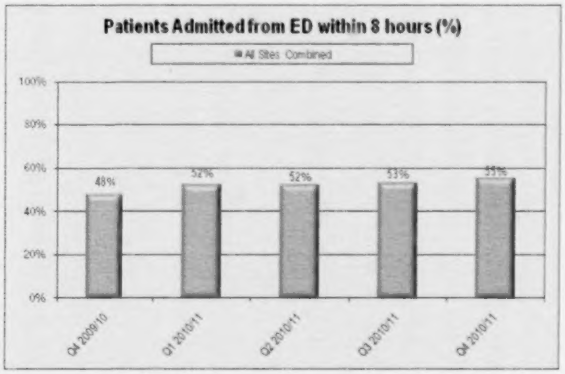
ED patients requiring hospital admission should be admitted to the appropriate inpatient environment in a timely fashion. Total time spent by a patient in an ED can be a measure of access to the health care system and a reflection of efficient use of resources.

WHAT IS THE TARGET?

Alberta Health Services (AHS) has established a target for all ED sites combined of 55 per cent of patients admitted leaving the ED within eight hours.

HOW ARE WE DOING?

In Q4 2010/11, 55 per cent of admitted patients left the ED within eight hours.



Source: Calgary and Edmonton Emergency Department Information System Data (REDIS,EDIS) and AHS Ambulatory Care Reporting System Data (ACRS, NACRS)

PERFORMANCE STATUS	2010/11 TARGET: 55% Q4 TARGET: 55%
Performance is at or better than quarterly target, continue to monitor. Baseline 2008/09: 48%	Q4 ACTUAL: 55%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A total of 323 new hospital beds have been opened in Calgary and Edmonton as of March 31, 2011 to improve patient flow. Staffing schedules at Health Link Alberta have also been optimized to match call presentation patterns, and a radio campaign was launched to promote the benefits of Health Link Alberta and urgent care centres. Additional efforts have been focused at those sites which remain below target. Calgary zone (Foothills Medical Centre, Rockyview General Hospital, Peter Lougheed Centre):

- Addition of the equivalent of 10 FTE's of physician support in the ED (e.g. the on-call ED physician has been accessed 70-80 per cent of the time)
- Bed huddles implemented three times a day
- Software implemented to initiate earlier discharge planning on inpatient units
- Optimization of Medical Assessment Unit (Rockyview)
- Ongoing implementation of over-capacity protocols
- Monitoring of Length of Stay data for those services that are above the national average and developing strategies and processes to reduce LOS

Edmonton Zone (University of Alberta Hospital, Royal Alexandra Hospital, Grey Nuns Community Hospital, Misericordia, Sturgeon Community Hospital):

- Medicine Unit Manager coverage expanded to the weekend and initiation of weekend bed huddle meetings to enhance patient movement out of ED seven days per week (Royal Alexandra)
- Expanded bed huddles with support services to develop daily plans to expedite transfer of patients to inpatient bed spaces
- Addition of a Triage Liaison Physician to facilitate timely consults, review admission issues, need for telemetry and suggest orders to ensure patients requiring admission are moved in a timely manner
- The Sturgeon facility moved into its new physical ED space; education on redesigned ED processes delivered to physicians and nurses

Performance Measure Update continues on next page ...

- Length of stay (LOS) task force established and LEAN training delivered to managers, directors, educators and unit supervisors to identify further opportunities for reducing LOS
- Outpatient services were redesigned to be able to accommodate earlier discharged/more complex inpatients (Glenrose Rehabilitation Hospital)

Subsequent actions planned: The five-year expansion plan for additional continuing care spaces is expected to reduce ED length of stay for patients requiring admission from ED.

Calgary Zone (Foothills, Rockyview, Peter Lougheed):

- Process improvement efforts to reduce: (1) time between triage and admission process; and (2) turn-around time for inpatient bed availability
- Additional community capacity planned for Alternate Level of Care, Mental Health and Home Care
- Ongoing work with Mental Health on transition units to support transfer of mental health patients where appropriate
- Work is ongoing with Community partners to identify opportunities for decreasing the number of patients on delay for supported living

Edmonton Zone (U of A, Royal Alexandra, Grey Nuns, Misericordia, Sturgeon):

- Implementation of software using real-time information from the ED to display patient volumes, incoming EMS volumes and the severity of patient conditions across Edmonton sites (the system has been used in Calgary since 2007 and has helped to provide a window into ED workload, assist with managing existing capacity and allow EMS to return to work faster)
- Increases to the number of daily bed huddles
- Sharing of the most effective/efficient triage models across inpatient services to improve flow
- I-Care Unit to open at U of A to accommodate general internal medicine patients that require closer observation and telemetry for a further 24-48 hours (patients previously boarded in ED)
- Ongoing review of ED patients exceeding the eight hour target: examination of barriers, issues and opportunities for improvement
- Addition of 12 new treatment spaces to the Stollery Children's Hospital ED is on track for March 2012

WHAT ELSE DO WE KNOW?

There are many reasons why length of stay may vary across sites. Examples include the complexity of patient conditions presenting to ED, capacity limitations (e.g. treatment spaces, staffing levels) as well as operational efficiency. In addition, the demand for ED services can vary significantly between sites and/or communities as a result of access to other primary care options (e.g. family physicians, walk-in clinics).

Information is available by site and zone.

Weekly ED Length of Stay (LOS) is available for a subset of sites where more timely data is readily available.

HOW DO WE COMPARE?

Relevant national comparisons will be included as available.

Alberta Health Services

Performance Measure Update

Data updated quarterly.
Most current data is Q4 2010/11.
Next data update expected for Q1 2011/12

People Waiting in Acute/Sub-Acute Beds for Continuing Care Placement

PERFORMANCE STATUS

Performance is within acceptable range of target, monitor and take action as appropriate.
Baseline March 31, 2010: 777

2010/11 TARGET: 400
Q4 TARGET: 400

Q4 ACTUAL: 471

WHAT IS BEING MEASURED?

People waiting in acute/sub-acute (hospital) beds for continuing care placement is a count of the number of persons who have been assessed and approved for placement in continuing care, who are waiting in a hospital acute care or sub-acute bed. This includes acute care palliative and acute mental health. The numbers presented represent a snapshot of the last day of the reporting period.

Detailed indicator definition is available.

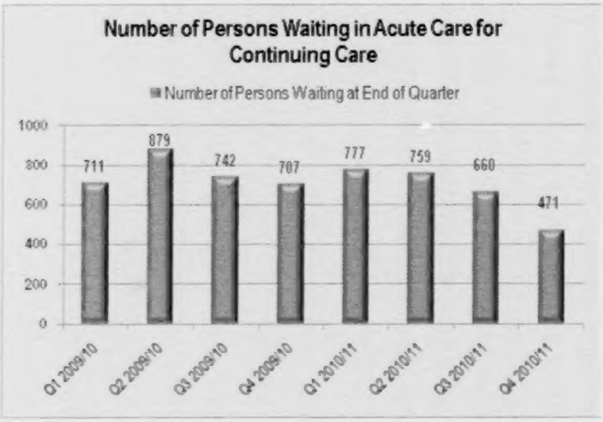
WHY IS THIS IMPORTANT?

Access to continuing care services is a significant issue in Alberta. As such, a focused, multiple-strategy approach is needed to provide both seniors and persons with disabilities more options for quality accommodations specific to their service needs and lifestyles.

By reducing the number of people waiting in a hospital environment for continuing care, we will be able to improve patient flow throughout the system, provide more appropriate care to meet patient needs, decrease wait times and deliver care in a more cost effective manner.

WHAT IS THE TARGET?

The target for 2010/11 is for 400 or fewer people to be waiting in acute/sub-acute (hospital) beds for continuing care placement. This is a decrease from the baseline of 700 in 2008/09.



Source: AHS "Snapshots" of the Wait List at the end of the month

HOW ARE WE DOING?

At the end of Q4 2010/11, 471 people were waiting in acute/sub-acute (hospital) beds for continuing care placement, which is above the target of 400.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: 1,166 continuing care spaces were opened across the province as of March 31, 2011. This represents the number of incremental continuing care spaces established. In addition, Home Care services continue to be expanded across the province. As well, implementation has begun on an "ED2Home" program to expedite discharge of seniors and disabled adults from the Emergency Department to their homes with appropriate connections to community supports, thus reducing avoidable stays in a hospital bed.

Subsequent actions planned: An additional 1,000 continuing care spaces are planned to open during the 2011/12 year. This number builds off the 1,166 spaces opened in 2010/11, and serves as the next phase towards the long-term target of opening 5,300 new continuing care spaces by 2015. Roll-out of new programs such as ED2Home will be expanded. Planning is also underway to identify additional strategies to reduce the number of persons waiting in acute/sub-acute beds for continuing care (including expansion in the number of clients receiving Home Care services).

WHAT ELSE DO WE KNOW?

The decisions made by the working group reviewing areas of ambiguity in the guidelines will be posted on the internal staff AHS website for reference by case managers.

Information is available by zone.

HOW DO WE COMPARE?

Relevant national comparisons will be included as available.

Data updated quarterly.
Most current data is Q4 2010/11.
Next data update expected for Q1 2011/12.

People Waiting in Community for Continuing Care Placement

● PERFORMANCE STATUS	2010/11 TARGET: 975 Q4 TARGET: 975
Performance is outside acceptable range, take action and monitor progress. Baseline March 31, 2010: 1,233	Q4 ACTUAL: 1,115

WHAT IS BEING MEASURED?

People waiting in community for continuing care placement is a count of the number of persons who have been assessed and approved for placement in continuing care, and are waiting in the community (at home). The numbers presented are a snapshot of the last day of the reporting period.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

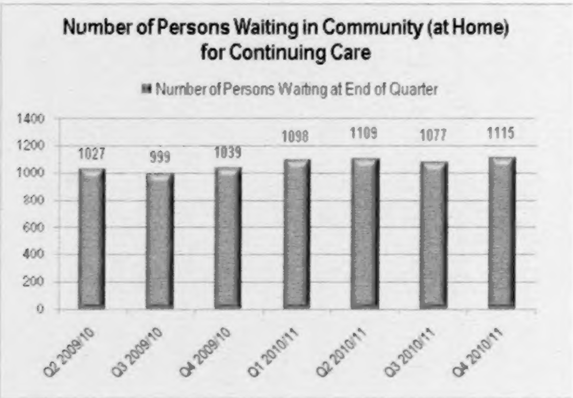
Access to continuing care services is a significant issue in Alberta. As such, a focused, multiple-strategy approach is needed to provide both seniors and persons with disabilities more options for quality accommodations specific to their service needs and lifestyles.

WHAT IS THE TARGET?

The target for 2010/11 is for 975 or fewer people to be waiting in the community (at home) for continuing care placement. This is a decrease from the baseline of 1,065 in 2008/09.

HOW ARE WE DOING?

At the end of Q4 2010/11, 1,115 people were waiting in the community (at home) for continuing care placement, which is above the target of 975.



Source: AHS 'Snapshots' of the Wait List at the end of the quarter

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: 1,166 continuing care spaces were opened across the province as of March 31, 2011. This represents the number of incremental continuing care spaces established. In addition, plans have been approved to expand Home Care hours to allow at least 3,000 more people to receive Home Care services in the year (e.g. through increased funding for Home Care service providers, enhancing existing services, as well as expanding eligibility for Home Care support).

Subsequent actions planned: An additional 1,000 continuing care spaces are planned to open during the 2011/12 year. This number builds off the 1,166 spaces opened in 2010/11, and serves as the next phase towards the long-term target of opening 5,300 new continuing care spaces by 2015. Planning is also underway to identify additional strategies to reduce the number of persons waiting in the community for continuing care (including expansion in the number of clients receiving Home Care services).

WHAT ELSE DO WE KNOW?

The decisions made by the working group reviewing areas of ambiguity in the guidelines will be posted on the internal staff AHS website for reference use by case managers.

Information is available by zone.

HOW DO WE COMPARE?

No national benchmark comparisons were found.

Performance Measure Update

Average Wait Time in Acute/Sub-Acute Care for Continuing Care

Data updated quarterly.
Most current data is Q4 2010/11.
Next data update expected for Q1 2011/12

WHAT IS BEING MEASURED?

Average Wait Time in Acute/Sub-Acute Care for Continuing Care measures the average number of days between an individual being assessed and approved for continuing care placement and their admission date to a Long Term Care Facility or Supportive Living space. Currently, summary data is provided by nine former health regions and collated.

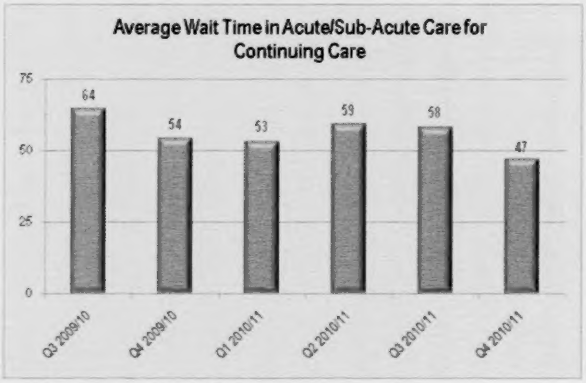
The average wait time may be overstated by days spent waiting in the Community prior to admission (i.e. only a portion of the wait was spent in Acute/Sub-acute Care), as well as "delay" days in Acute/Sub-acute Care (i.e. days where hospitalization is required due to an individual becoming medically unstable – continuing care placement is delayed until their medical condition stabilizes).

Detailed indicator definition is currently in development.

WHY IS THIS IMPORTANT?

Access to continuing care services is a significant issue in Alberta. As such, a focused, multiple-strategy approach is needed to provide both seniors and persons with disabilities more options for quality accommodations specific to their service needs and lifestyles.

By reducing the wait time and the number of people waiting in a hospital environment for continuing care, we will be able to improve patient flow throughout the system, provide more appropriate care to meet patient needs, and deliver care in a more cost effective manner.


Average Wait Time in Acute/Sub-Acute Care for Continuing Care

Source: Continuing Care Wait Time Data
Note: Figures will be revised as available.

PERFORMANCE STATUS	2010/11 TARGET: TBD
Performance Target for 2010/11 has not been established for comparison.	Q4 ACTUAL: 47

WHAT IS THE TARGET?

Targets are currently being developed for this indicator.

HOW ARE WE DOING?

The average wait time in acute/sub-acute care for continuing care was 47 days in Q4 of 2010/11.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: 1,166 continuing care spaces were opened across the province as of March 31, 2011. This represents the number of incremental continuing care spaces established. In addition, Home Care services continue to be expanded across the province. As well, implementation has begun on an "ED2Home" program to expedite discharge of seniors and disabled adults from the Emergency Department to their homes with appropriate connections to community supports, thus reducing avoidable stays in a hospital bed.

Subsequent actions planned: An additional 1,000 continuing care spaces are planned to open during the 2011/12 year. This number builds off the 1,166 spaces opened in 2010/11, and serves as the next phase towards the long-term target of opening 5,300 new continuing care spaces by 2015. Roll-out of new programs such as ED2Home will be expanded. Planning is also underway to identify additional strategies to reduce waiting time for continuing care (e.g. expanding the number of clients receiving Home Care services, expanding the role of transition coordinators, facilitating advanced discharge planning with patients and their families).

WHAT ELSE DO WE KNOW?

Information is available by zone.

HOW DO WE COMPARE?

National benchmark comparisons are not available.

Performance Measure Update

Number of Home Care Clients

Data updated quarterly.
Most current data is Q4 2010/11.
Next data update expected for Q1 2011/12.

WHAT IS BEING MEASURED?

Number of Home Care Clients measures the number of unique / individual clients served during the reporting period. This includes all clients in all age groups within former categories of short term, long term, and palliative, as well as day programs, Supportive Living Level 1, and Supportive Living Level 2.

Detailed indicator definition is currently in development.

WHY IS THIS IMPORTANT?

As the population ages, providing seniors with access to services and supports to remain healthy and independent as long as possible has never been more important. Enhancing support services and offering more choice and care options to Albertans in their homes is a key strategy to enable individuals to “age in the right place”.

WHAT IS THE TARGET?

Targets are currently being developed for this indicator.

HOW ARE WE DOING?

The number of unique / individual Home Living Clients was 56,041* in Q4 of 2010/11.

Table: Number of Home Living Clients

Time Period	Home Care Clients
Q1 2010/11	55,593
Q2 2010/11	55,617
Q3 2010/11	55,543
Q4 2010/11	56,041*

Source: AHS
* Q4 2010/11 includes estimated data for Central Zone.

PERFORMANCE STATUS

Performance Target for 2010/11 has not been established for comparison.

2010/11 TARGET: TBD

Q4 ACTUAL: 56,041

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Plans have been approved to expand Home Care hours to allow at least 3,000 more people to receive Home Care services in the year (e.g. through increased funding for Home Care service providers, enhancing existing services, as well as expanding eligibility for Home Care support). Home Care coordinators in the Emergency Department (ED) have also been established to assess and coordinate the needs of patients and their families and to facilitate safe discharge from ED and expedited access to home care services.

Subsequent actions planned: Implementation will continue to meet the goal of expanding Home Care to at least 3,000 more people per year by March, 2012. Planning is also underway to enhance the level and amount of Home Care support to existing and future clients (e.g. increasing the dollars available for short-term Home Care services to support patients’ transition from hospital/ED to their home living environment, providing 24/7 telephone access to a Home Care case coordinator, increasing available Home Care services on weekends and holidays).

WHAT ELSE DO WE KNOW?

Information is available by zone.

HOW DO WE COMPARE?

National benchmark comparisons are not available.

Performance Measure Update

Most current data is 2008
The next survey is not yet scheduled

Rating of Care
Nursing Home – Family

WHAT IS BEING MEASURED?

The Health Quality Council of Alberta (HQCA) asked family members of Alberta nursing home residents about their rating of the care in the Alberta Long Term Care Family Experience Survey. The first report was released in 2008 and is based on a survey from October 2007. The next report is scheduled for release later in 2011.

Rating of Care Nursing Home – Family measures the overall family rating of care at Alberta nursing homes, on a scale from 0 to 10. The average score is reported.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

This global rating of care is an overall judgment by family members about the quality of care provided to their loved one. We know this rating is significantly influenced by the specific issues captured in the complete survey, and we also see there is considerable performance variation in this rating between facilities in the province. It is most relevant and important for facility level results. Low performing facilities will need to improve for the provincial aggregate score to improve. Average or high performing facilities will need to maintain their performance. Low performing facilities should learn from high performing facilities.

WHAT IS THE TARGET?

Alberta Health Services (AHS) has not yet established a 2010/11 target for the average overall family rating of care at Alberta nursing homes.

HOW ARE WE DOING?

In 2008 the average overall family rating of care at Alberta nursing homes was 8.1, on a scale from 0 to 10.

Table: Global Rating of Care at the Nursing Home (2008)

Province	Average Score
Alberta	**8.1**

Source: Health Quality Council of Alberta (HQCA) Alberta Long Term Care Family Experience Survey

PERFORMANCE STATUS

Performance Target for 2010/11 has not been established for comparison.

2010/11 TARGET: TBD

2008 ACTUAL: 8.1

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: The 2010 Long Term Care Family Experience Survey was issued by HQCA in late 2010 to all families identified by the province's long term care facilities. Surveys have since been returned by mail, and all data entry and validation has been completed. HQCA is currently in the process of analyzing the data and developing the final report.

Subsequent actions planned: HQCA will complete the survey analysis including comparison with the 2007 survey. Public release of the report is slated for Summer 2011. AHS will then review the results, identify opportunities for improvement, and develop and implement action plans as appropriate. Future surveys are anticipated to occur on a rotating 3-year basis, dependent on budget approval.

WHAT ELSE DO WE KNOW?

High level surveys and aggregate results do not capture the unique nature of individual family experiences and the sometimes significant challenges and issues they face.

We know that smaller facilities and facilities in small communities are pre-disposed to better performance in terms of family and resident experience ratings. Despite this, there is still considerable variation in performance between facilities which are comparable in size and location.

HOW DO WE COMPARE?

National benchmark comparisons are not currently available. The survey instrument is available in the public domain and has been adopted in part by the Ontario Government and Ontario Quality Council, future benchmarks and comparisons are likely possible.

Most current data is 2008.
The next survey is not yet scheduled.

Rating of Care
Nursing Home – Resident

WHAT IS BEING MEASURED?

The Health Quality Council of Alberta (HQCA) asked residents of Alberta nursing homes about their rating of the care in the Alberta Long Term Care Resident Experience Survey. The first report was released in 2008 and is based on a survey conducted between June and August of 2007. The next Alberta Long Term Care Resident Experience Survey has not yet been scheduled.

Rating of Care Nursing Home – Resident measures the overall resident rating of care at Alberta nursing homes, on a scale from 0 to 10, the average score is reported.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

This global rating of care is an overall judgment by residents about the quality of care provided. We know this rating is significantly influenced by the specific issues captured in the complete survey, and we also see there is considerable performance variation in this rating between facilities in the province. It is most relevant and important for facility level results. Low performing facilities will need to improve for the provincial aggregate score to improve. Average or high performing facilities will need to maintain their performance. Low performing facilities should learn from high performing facilities.

WHAT IS THE TARGET?

Alberta Health Services (AHS) has not yet established a 2010/11 target for the average overall resident rating of care at Alberta nursing homes.

HOW ARE WE DOING?

In 2008 the average overall resident rating of care at Alberta nursing homes was 8.1, on a scale from 0 to 10.

Table: Overall Care Rating (2008)

Province	Average Score
Alberta	**8.1**

Source: Health Quality Council of Alberta (HQCA) Alberta Long Term Care Resident Experience Survey

PERFORMANCE STATUS

Performance Target for 2010/11 has not been established for comparison.

2010/11 TARGET: TBD

2008 ACTUAL: 8.1

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: 200 beds were opened at Michener Hill in Red Deer. Provincial education for behavioral and symptom management was undertaken with three rural communities receiving training on best practices in nursing care to older adults. A review of access to specialized geriatric consultative services was also completed.

Subsequent actions planned: A report on the financial barriers to obtaining timely Living Option access will be completed in early 2011. As well, the current training program will be reviewed to develop a distributive model of education that will spread best practices in a more efficient way.

WHAT ELSE DO WE KNOW?

Due to issues of cognitive function, only about 35 per cent of Long Term Care residents are capable of completing an interview. The result is very small sample sizes at the facility level. It is likely that no measurement process in this population could avoid this problem.

High level surveys and aggregate results do not capture the unique nature of individual resident experiences and the sometimes significant challenges and issues they face.

We know that smaller facilities and facilities in small communities are pre-disposed to better performance in terms of family and resident experience ratings. Despite this, there is still considerable variation in performance between facilities which are comparable in size and location.

HOW DO WE COMPARE?

National benchmark comparisons are not currently available. The survey instrument is available in the public domain and has been adopted in part by the Ontario Government and Ontario Quality Council, future benchmarks and comparisons are likely possible.

Performance Measure Update

Head Count to FTE Ratio

Data updated quarterly.
Most current data is Q4 2010/11.
Next data update expected for Q1 2011/12.

WHAT IS BEING MEASURED?

The Head Count to FTE (Full-Time Equivalent) Ratio is the number of people employed by Alberta Health Services for every 1 FTE. A full-time equivalent is the number of hours that represent what a full time employee would work over a given time period, for example a year or a pay period.

The measure is calculated as the number of unique/discrete individuals employed by Alberta Health Services (AHS) divided by the reported assigned FTE level for all employees. A lower ratio (lower number of head count to FTE) reflects optimization of workforce.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

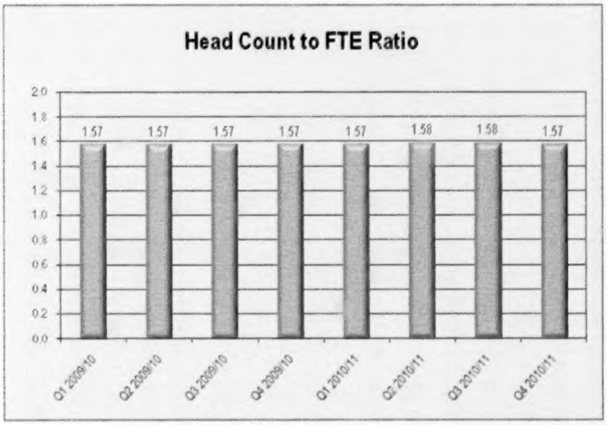
The performance of our health care system is directly related to the people who provide care and services to the citizens and communities we serve. This measure also supports workforce efficiencies and indicates better ability to effectively manage scheduling and productivity challenges.

WHAT IS THE TARGET?

AHS has established a 2010/11 target head count to FTE ratio of 1.63. AHS will decrease the head count to FTE ratio.

HOW ARE WE DOING?

In 2009/10 the head count to FTE ratio was 1.57. In Q1 2010/11 the ratio was 1.57. In Q2 and Q3 2010/11 the ratio was 1.58 and back to 1.57 in Q4. No change from 2009/10.



Source: Alberta Health Services Human Resources

PERFORMANCE STATUS

Performance is at or better than target, continue to monitor.

2010/11 TARGET: 1.63

Q4 2010/11 ACTUAL: 1.57

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: The health workforce summit held in November 2010 brought 100 front line clinicians, managers, union leaders, regulators and educators together to continue a dialogue about workforce issues. The summit built on consultations held across the province during the first two quarters of the year about what AHS' workforce planning priorities and actions should be going forward. A number of themes emerged from those consultations and were further explored during the summit. A high degree of consensus was reached and AHS clearly achieved an agenda to move forward on issues such as retention and recruitment, the efficient utilization of the clinical workforce and shaping future workforce requirements.

This Clinical Workforce Strategic Plan is imperative in identifying the most effective Head Count to FTE mix.

Subsequent actions planned: A Clinical Workforce Strategic Plan will be developed by March, 2011. This plan is imperative in identifying the most effective head count to FTE mix.

WHAT ELSE DO WE KNOW?

The head count includes full-time, part-time and casual employees. The FTE includes full-time, and part-time employees as casual employees have no assigned FTE.

This measure could be skewed due to a reduction in the casual workforce rather than the creation of fuller employer opportunities.

This measure does not include Capital Care Group, Calgary Laboratory Services or Carewest even though these are wholly owned entities of AHS. Some employees currently not on AHS pay systems may not be included (e.g., Emergency Medical Services).

HOW DO WE COMPARE?

This measure is not benchmarked externally.

TIP #4

Performance Measure Update

Registered Nurse Graduates Hired by AHS (%)

Data updated quarterly.
Most current data is Q4 2010/11.
Next data update expected for Q1 2011/12.

PERFORMANCE STATUS

Continue to monitor performance.

2010/11 TARGET:
70%

2010/11 ACTUAL:
▢ Total: 87%
● Non-Casual: 41%

WHAT IS BEING MEASURED?

The percentage of Registered Nurse (RN) graduates hired by Alberta Health Services (AHS) measures the estimated number of RN graduates for the given year and the number of hires likely to be new university/college registered nursing graduates.

As the actual number of graduates for a given year is not known until November, the number of graduates from the previous year is used.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

The performance of our health care system is directly related to the ability of AHS to sustain the delivery of nursing care services, by utilizing a locally educated nursing workforce.

A commitment has been made in the 2010-13 United Nurses of Alberta (UNA) collective agreement stating AHS will hire a minimum of 70 per cent of Alberta nursing graduates positions annually. If 70 per cent of Alberta nursing student graduates are not hired into regular or temporary positions of greater than six month, the UNA Joint Committee will examine the reasons.

WHAT IS THE TARGET?

Consistent with the UNA Collective Agreement, AHS has established a target of 70 per cent of Alberta graduates hired in 2010/11. The percent of graduates hired into non-casual positions will also be reported.

HOW ARE WE DOING?

As the numbers of RN graduates for the previous year are not available until November, the number of graduates from 2008/09 is used. Alberta Advanced Education reported there were 1,582 Alberta RN graduates in 2008/09.

By the end of fiscal year 2010/11 AHS hired 1,383 (87 per cent) RN graduates. Of these, 653 (41 per cent) were hired into non-casual positions.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Progress on various initiatives include: initiation of a "Transitional Grad Nurse Program", commencement of a targeted recruitment initiative to retain the current new graduates and attract future classes, early development of a Northern Recruitment Strategy to encourage new graduates to apply for job opportunities outside of the major urban centres, as well as early development of professional practice and specialty-specific orientations to support new hires. In addition, grant funding has been received for a multi-stakeholder provincial steering committee – *"The Successful Transition of the Newly Graduated Nurse"* – to develop a resource tool kit to support the successful transition of new graduates to the workplace.

Subsequent actions planned include: implementing the Transitional Grad Nurse Program, continuing with the targeted recruitment plan for new graduates, enhancing the recruitment strategy and actively marketing job opportunities with AHS for new graduates, implementing the professional practice orientation, and implementing the Northern Recruitment Strategy with a view to building upon it to attract new graduates in rural areas.

WHAT ELSE DO WE KNOW?

Recruitment challenges may exist in certain "difficult to recruit to" areas. For example, vacancies in rural/remote locations due to many new graduates seeking employment in the metro areas; as well, new graduates are not necessarily competent to work in specialized areas without additional support. In addition, collective agreement requirements to hire internal candidates wherever possible can put new graduates at a disadvantage.

The collection of relevant data is difficult due to system issues. AHS does not currently track the source of new hires. This measure refers to those nurses compensated at a Step One level, and may include new grads from outside Alberta as well as RNs whose previous experience has not yet been verified for step increments. Once experience is verified, adjustments will be made.

HOW DO WE COMPARE?

This measure is not benchmarked externally.

TIP # 4

Performance Measure Update

Disabling Injury Rate

Data updated quarterly
Most current data is Calendar Year 2011 Q1
Next data update expected for Q1 2011/12

● **PERFORMANCE STATUS**

Performance is outside acceptable range, take action and monitor progress.
Baseline 2009: 2.83

2011 CY TARGET: 2.20

2011 CY Q1 (Jan-Mar) ACTUAL: 0.70
2011 CY ANNUALIZED: 3.14

WHAT IS BEING MEASURED?

The number of disabling injury claims per 100 AHS workers is calculated as: the number of disabling injury claims accepted from Alberta Health Services by the Workers' Compensation Board (WCB) in Alberta multiplied by 100 and divided by Alberta Health Services person-years.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

The performance of our health care system is directly related to the health and wellness of the people who provide care and services. Alberta Health Services (AHS) is committed to enabling staff to deliver high quality and safe care by providing the appropriate supports, such as education, a safe and supportive work environment and the required tools.

WHAT IS THE TARGET?

AHS has established a 2010 target of 2.41 disabling injury claims per 100 workers. This represents a 15 per cent reduction in the disabling injury rate for the calendar year.

HOW ARE WE DOING?

In 2009, the disabling injury rate was 2.83. In 2010 the disabling injury rate was 3.19. This represents a 13 per cent increase in the disabling injury rate. For the 2011 Q1 (Jan-Mar) the actual disabling injury rate was 0.70. If this rate continues the annual projected disabling rate for 2011 would be 3.14

Table: Disabling Injury Claims per 100 Workers

Time Period	Disabling Injury Rate
2009	2.83
2010	3.19

Source: Alberta Health Services and Alberta Workers' Compensation Board (WCB)

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Over 1,750 staff have been trained and 151 ceiling lifts have been installed in acute care environments in three Zones (South, North and Edmonton) as part of the Safe Client Handling Program. As well, Workplace Health and Safety Improvement Plans for 2011-12 are currently being developed with improved processes and metrics based on learnings from the 2010-11 year.

Subsequent actions planned: Implementation of the Safe Client Handling Program will continue. As well, AHS will partner with WCB to develop an improvement plan for 2011-12. One initiative in particular is to aggressively target and reduce lost time claims of under eight days duration.

WHAT ELSE DO WE KNOW?

The data for this measure is provided by WCB Alberta and is a measure of the calendar year rather than the fiscal year.

The calendar year rate (AHS Q3) may be adjusted by WCB in the first quarter of 2011 once WCB conducts the yearly reconciliation. WCB will adjust for the additional 2010 transactions to year end and will calculate person years based on actual rather than estimated payroll.

Previous years are not available by quarter or other time sub-sets. From 2010 forward, WCB Alberta will provide quarterly data. Caution must be used when comparing this measure over time as it is reported cumulatively throughout the calendar year (Q1 = 3 months of data, Q2 = 6 months, etc). Starting in 2011, quarterly intervals will be comparable.

HOW DO WE COMPARE?

In 2009, the disabling injury rate for AHS was slightly better than the industry average. However, as an industry, healthcare's disabling injury rate is about average when compared with all Alberta industries.

Alberta Health Services

TIP #4

Most current data is 2009/10.
The next survey is planned for 2012

Performance Measure Update

Staff Overall Engagement (%)

WHAT IS BEING MEASURED?

Staff overall engagement measures the per cent of Alberta Health Services employees (excluding physicians and volunteers) who report they are favorably engaged at work. To determine the level of staff engagement, AHS undertook a workforce engagement survey in January/February 2010.

Results were calculated as the number of positive category responses (strongly agree or agree), divided by the total number of responses across all categories (strongly agree, agree, neutral, disagree, strongly disagree, not applicable) to the survey's seven engagement questions:

1. I am proud to tell others I am associated with Alberta Health Services.
2. I am optimistic about the future of Alberta Health Services.
3. Alberta Health Services inspires me to do my best work.
4. I would recommend Alberta Health Services to a friend as a great place to work.
5. My work provides me with sense of accomplishment.
6. I can see a clear link between my work and Alberta Health Services long-term objectives.
7. Overall, I am satisfied with Alberta Health Services.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

The engagement of AHS' workforce is critical to the delivery of safe and quality health services to Albertans, and to the success of the organization. Studies have shown an engaged workforce results in improved performance, retention, productivity and patient satisfaction.

WHAT IS THE TARGET?

Alberta Health Services (AHS) has established a target of 43 per cent of employees reporting they are favorably engaged at work for 2010/11 and 2011/12.

HOW ARE WE DOING?

Of the employees responding to the 2009/10 engagement survey, 35 per cent reported that they were favorably engaged.

The results of this first workforce engagement survey will serve as a baseline on which to assess future performance. Subsequent surveys are planned to occur every two years.

● **PERFORMANCE STATUS**

Performance is outside acceptable range of 2010/11 target (>10%), take action and monitor progress.

2010/11 TARGET
43%

2009/10 ACTUAL
35%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Early implementation of a Leadership Program, establishment of a Provincial Working Group for the Just and Trusting Culture initiative, establishment of a Learning and Professional Development Fund, development of a process for informal employee appreciation, establishment of various programs for management and out-of-scope staff (compensation, flex benefits, career framework. In addition, many recruitment strategy components are underway with engagement from an employee working group.

Subsequent actions planned include presentations for Long Service Awards, roll-out of a performance management process for unionized staff, development of a rewards and recognition program for staff (as part of a broader Workforce Engagement framework), roll-out of leadership competencies to managers across the organization, as well as preliminary planning for the next Workforce Engagement Survey in early 2012 (will be repeated every two years).

WHAT ELSE DO WE KNOW?

Timing of the survey may have had an impact on both the results, as well as the low response rate for employees (21 per cent). Uncertainties related to the AHS budget, the implementation of a vacancy management process, the potential for staff layoffs, and other factors occurring at the time of the survey could have influenced the survey results.

Information is available by zone.

HOW DO WE COMPARE?

The survey was administered by an external third party provider (TalentMap). Based on engagement data drawn from 28 Canadian healthcare organizations (40 per cent from Western Canada), TalentMap's Healthcare Benchmark for overall engagement is 76 per cent. This is significantly higher than the AHS employee engagement survey result.

TIP #4

Performance Measure Update

Physician Overall Engagement (%)

Most current data is 2009/10
The next survey is planned for 2012

WHAT IS BEING MEASURED?

Physician overall engagement measures the per cent of physicians associated with AHS who report they are favorably engaged in this association. To determine the level of physician engagement, Alberta Health Services undertook a workforce engagement survey in January/February of 2010.

Results were calculated as the number of positive category responses (strongly agree or agree), divided by the total number of responses across all categories (strongly agree, agree, neutral, disagree, strongly disagree, not applicable) to the survey's seven engagement questions:

1. I am proud to tell others I am associated with Alberta Health Services.
2. I am optimistic about the future of Alberta Health Services.
3. Alberta Health Services inspires me to do my best work.
4. I would recommend Alberta Health Services to a friend as a great place to work.
5. My work provides me with sense of accomplishment.
6. I can see a clear link between my work and Alberta Health Services long-term objectives.
7. Overall, I am satisfied with Alberta Health Services.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

The engagement of the AHS physician community is critical to the delivery of safe and quality health services to Albertans and to the success of the organization. Studies have shown an engaged workforce results in improved performance, retention, productivity and patient satisfaction.

WHAT IS THE TARGET?

Alberta Health Services has established a target of 43 per cent of the physician community reporting they are favorably engaged at work for 2010/11 and 2011/12.

HOW ARE WE DOING?

Of the physicians responding to the 2009/10 engagement survey, 26 per cent reported they were favorably engaged.

The results of this first workforce engagement survey will serve as a baseline on which to assess future performance. Subsequent surveys are planned to occur every two years.

● **PERFORMANCE STATUS**

Performance outside acceptable range of 2010/11 target (>10%), take action and monitor progress.

2010/11 TARGET
43%

2009/10 ACTUAL
26%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: In addition to the strategies identified under AHS' Workforce Engagement Plan (which includes physicians), a Physician Engagement Plan has been developed and each Zone Medical Affairs group has articulated a local plan for enhancing physician participation and engagement. A medical staff website was implemented on the external AHS website as part of the AHS Physician communication strategy. Accreditation activities were also used as an opportunity to facilitate physician participation in AHS processes.

Subsequent actions planned: A rewards and recognition program for physicians will be implemented later in 2011. As well, negotiations will continue between AHS, Alberta Health and Wellness (AHW), and the Alberta Medical Association (AMA) on the next Trilateral Master Agreement.

WHAT ELSE DO WE KNOW?

The timing of the survey may have had an impact on both the poor results, as well as the low response rate for physicians (12 per cent). Uncertainties related to the AHS budget, the implementation of a vacancy management process, the potential for staff layoffs, and other factors occurring at the time of the survey, could have influenced the survey results.

Information is available by zone.

HOW DO WE COMPARE?

The survey was administered by an external third party provider (TalentMap). Based on engagement data drawn by from 28 Canadian healthcare organizations (40 per cent from Western Canada), TalentMap's Healthcare Benchmark for overall engagement is 76 per cent. This is significantly higher than the AHS physician engagement survey result

Alberta Health Services

TIP #4

Performance Measure Update

Full-time to Part-time Clinical Worker Ratio

Data updated quarterly.
Most current data is Q4 2010/11
Next data update expected for Q1 2011/12

PERFORMANCE STATUS

Performance Target for 2010/11 has not been established for comparison.

2010/11 TARGET: TBD

Q4 ACTUAL: 0.98

WHAT IS BEING MEASURED?

The Full-time to Part-time Clinical Worker Ratio is the number of full-time clinical people employed by Alberta Health Services for every one part-time employee.

A full-time employee is one who is hired to work the full specified annual hours of work. A part-time employee is one who is hired to work for scheduled shifts, and whose hours of work are less than the specified annual hours of work.

A clinical worker is one coded to 712, 713, 714 or 715 of the MIS Primary Chart of Accounts:

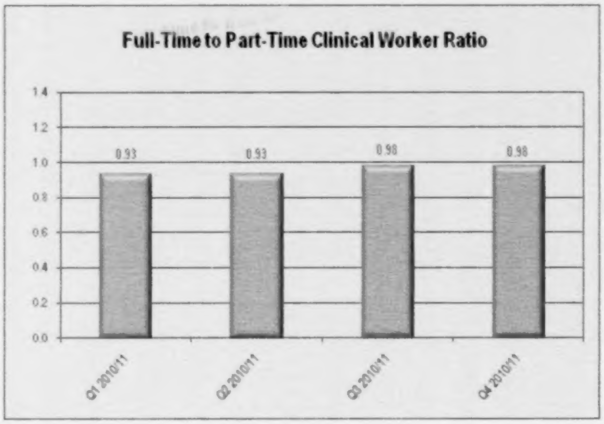
- 712XXXXXX–NURSING INPATIENT/RESIDENT SERVICES
- 713XXXXXX–AMBULATORY CARE SERVICES
- 714XXXXXX–DIAGNOSTIC & THERAPEUTIC SERVICES
- 715XXXXXX–COMMUNITY & SOCIAL SERVICES

The measure is calculated as the number of unique/discrete clinical individuals employed by AHS in full-time positions divided by the number of unique/discrete clinical individuals employed by AHS in part-time positions. A higher ratio (higher number of full-time to part-time clinical workers) reflects optimization of workforce.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

The performance of our health care system is directly related to the people who provide care and services to the citizens and communities we serve. This measure supports the clinical workforce efficiencies and indicates better ability to effectively manage scheduling and productivity challenges.



Source: Alberta Health Services Human Resources

WHAT IS THE TARGET?

AHS did not yet establish a 2010/11 target full-time to part-time clinical worker ratio. The target will be reviewed through the Strategic Clinical Workforce Plan by March, 2011 and will be set for 2011/12.

HOW ARE WE DOING?

In 2009/10 the full-time to part-time clinical worker ratio was 0.92. In Q1 and Q2 of 2010/11 the ratio was 0.93. In Q3 and Q4 of 2010/11 the ratio was 0.98 which is a positive trend. The ratio was 0.91 for the 2010/11 fiscal year.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A Clinical Workforce Strategic Plan (CWSP) has been developed and submitted to the Board for review/approval. Immediate actions arising from the CWSP have commenced, including preliminary workforce data projections for the next eight quarters by Zone and occupation. In addition, the Chief Executive Officer (CEO) has announced a target to increase the proportion of full-time positions by 6 per cent by 2012.

Subsequent actions planned: An implementation plan for the CWSP will be developed with short, medium and longer term actions. As well, an over-arching Program Charter for workforce initiatives will be developed by Spring 2011. Zone Workforce Planning infrastructure in alignment with Zone Integrated Plans will also be developed.

WHAT ELSE DO WE KNOW?

Note that this measure does not include the Capital Care Group, Calgary Laboratory Services or Carewest entities even though these are wholly owned entities of AHS. Some employees currently not on AHS pay systems may not be included (e.g., Emergency Medical Services).

Information will be available by zone.

HOW DO WE COMPARE?

This measure is not benchmarked externally.

Alberta Health Services

Performance Measure Update

Employee Absenteeism Rate

New measure Q4 2010/11.
Data updated quarterly.
Next data update expected for Q1 2011/12.

WHAT IS BEING MEASURED?

Absenteeism rate is the total sick leave hours (paid and unpaid plus Leave of Absence (LOA) Special & Family) of full-time and part-time employees converted to days by dividing by daily hours of work (7.75) per Full Time Equivalent (FTE).

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

The performance of our health care system is directly related to the people who provide care and services to the citizens and communities we serve. This measure also supports workforce efficiencies and indicates better ability to effectively manage scheduling and productivity challenges.

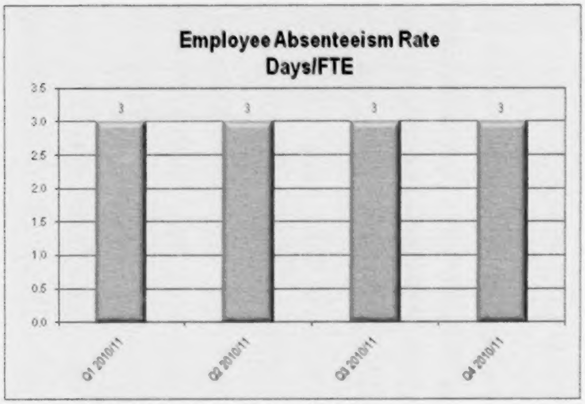
WHAT IS THE TARGET?

No targets have been defined. Baseline for Alberta Health Services (AHS) will be established and confirmed in 2010/11. A target will be set in early 2011/12.

HOW ARE WE DOING?

Sick leave days taken per FTE have remained fairly constant throughout the 2010/11 fiscal year at one per month or three per quarter. There was a slight drop in the summer months (Q2).

In 2010/11, AHS employees used 12.19 days per FTE.



Source: Alberta Health Services, Labour Cost System

PERFORMANCE STATUS

Performance Target for 2010/11 has not been established for comparison.

2010/11 TARGET:
TBD

Q4 2010/11 (annualized):
12 days/FTE

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Developing and implementing an Attendance Management program; redistributing Workplace Health and Safety (WHS) workload to allow advisors to bring attention to this measure with managers.

Subsequent actions planned: The WHS Indicator Development group is reviewing indicators available and meaningful to workplace health and safety. The group will be looking at meaningful analysis methods and reporting levels.

WHAT ELSE DO WE KNOW?

The number of sick leave days per FTE can be generated monthly, quarterly and annually. Monthly and quarterly data has been annualized for this measure.

HOW DO WE COMPARE?

In 2009/10, AHS had one of the lowest absenteeism rates of the seven western provinces' health regions participating in a survey.

	Overall (n=103)	**Public sector (n=41)**	**Private sector (n=62)**
Absenteeism rate* (days per FTE)	6.6	8.1	5.6

Source: the Conference Board of Canada. *Valuing Your Talent – June 2010*

Alberta Health Services

TIP #4

Performance Measure Update

Overtime Hours to Paid Hours

New measure Q4 2010/11.
Data updated quarterly.
Next data update expected for Q1 2011/12

WHAT IS BEING MEASURED?

The total overtime hours worked by employees divided by total paid hours is measured.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

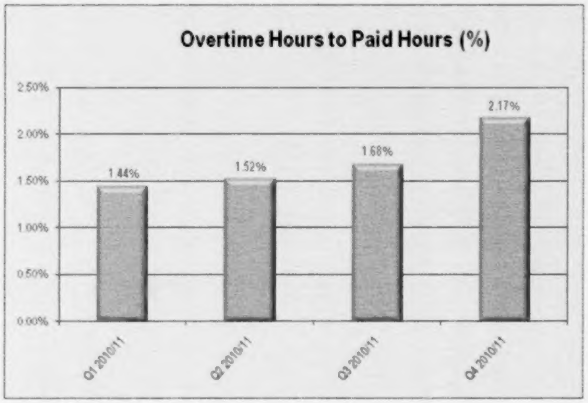
The performance of our health care system is directly related to the people who provide care and services to the citizens and communities we serve. This measure also supports workforce efficiencies and indicates better ability to effectively manage scheduling and productivity challenges.

WHAT IS THE TARGET?

No targets have been defined. Baseline will be established and confirmed in 2010/11.

HOW ARE WE DOING?

Overtime hours accounts for 1.70 per cent of total paid hours in 2010/11. This rate has been fairly constant throughout the 2010/11 fiscal year.



Source: Alberta Health Services, Labour Cost System

PERFORMANCE STATUS	**2010/11 TARGET: TBD**
Performance Target for 2010/11 has not been established for comparison.	**Q4 ACTUAL: 2.17%**

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: In the direct nursing functional bargaining unit a joint working group has been established to review the possibility of converting overtime hours (and others) into regular positions. As well, managers in all areas are responsible for adherence to budgets for their sections as part of the Alberta Health Services' (AHS) performance management process.

Subsequent actions planned: In the direct nursing functional bargaining unit, analysis will be undertaken on casual, overtime, additional part time and agency nursing hours to support the joint workforce regularization processes commencing in the Zones.

WHAT ELSE DO WE KNOW?

Measuring Overtime as a percentage of time worked helps AHS understand the impact that efficient organization of work has on the organization. Trends over time will allow us to monitor how well AHS is doing at creating an effective work mix.

HOW DO WE COMPARE?

In 2009/10, AHS had one of the lowest overtime to paid hours ratios of seven western provinces' health regions participating in a survey.

In a Conference Board survey, overtime expenses average approximately 5.7 per cent of gross annual payroll among the surveyed organizations. Since 1997, the ratio of overtime hours worked to workers' standard or usual hours of work has remained relatively constant, at about five per cent of all regular hours worked.

Source: The Conference Board of Canada. *Working 9 to 9. Overtime Practices in Canadian Organizations* – August 2009.

TIP #5

Performance Measure Update

Data updated quarterly.
Most current data is Q4 2010/11.
Next data update expected for Q1 2011/12.

Number of Netcare Users

WHAT IS BEING MEASURED?

The number of Netcare Users measures the number of physicians and nurses who access the Alberta Netcare Electronic Health Record (EHR) system across the continuum of care.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

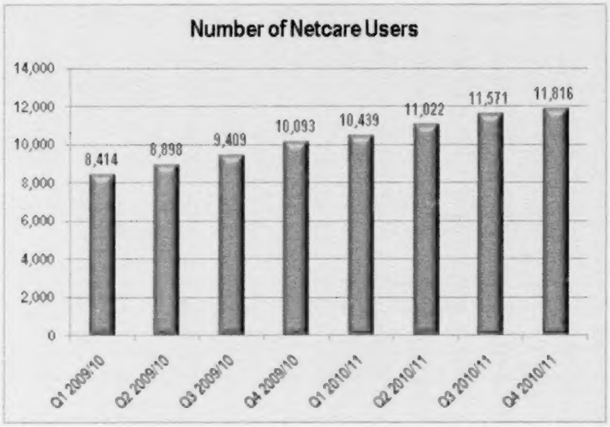
The Alberta Netcare EHR Portal improves patient care by providing up-to-date information immediately at the point of care. Making basic patient information available to health service providers supports better care decisions and improves patient safety.

WHAT IS THE TARGET?

Alberta Health Services (AHS) has established a target of a 15 per cent increase in Netcare users from 2009/10 to 2010/11.

HOW ARE WE DOING?

The peak quarterly number of nurses and physicians accessing Netcare was 11,816 in Q4 of 2010/11. This represents a 2 per cent increase over the previous quarter.



Source: Alberta Netcare Portal

▨ **PERFORMANCE STATUS**

Performance is at or better than target, continue to monitor.
Baseline 2009/10: 10,067

2010/11 TARGET: 11,575

Q4 ACTUAL: 11,816

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Recent activity has focused on enhancing both the number of Netcare users as well as expanding the scope of Netcare functionality for users in the Calgary Zone. As a result, Netcare usage within the Calgary Zone has expanded by 25% over the past 12 months.

Subsequent actions planned: Expansion of Netcare to additional users will continue in the months and years ahead. In the more immediate term, however, electronic viewing of Diagnostic Imaging tests will be made available to Netcare users by Summer 2011, which will have a province-wide positive impact on this measure for the new fiscal year. As well, the upcoming Netcare integration with other patient care information systems should increase significantly the rate of adoption for Calgary-based physicians and nurses in the coming months. In addition, Patient Events in selected sites are planned to be made available as part of the June 2011 (Edmonton, Cross Cancer Centre) and November 2011 (Calgary and Rural Zones) quarterly Netcare releases.

WHAT ELSE DO WE KNOW?

Alberta Netcare EHR Portal is a highly secure system that protects patient privacy and complies with the *Health Information Act* (HIA).

Information is available by zone.

HOW DO WE COMPARE?

National benchmark comparisons are not available.

Data updated quarterly.
Most current data is Q4 2010/11.
Next data update Q1 2011/12.

On Budget: Year To Date

WHAT IS BEING MEASURED?

On Budget Year to Date is an outcome measure that compares the AHS budgeted accumulated surplus (deficit) against the actual accumulated surplus values for the current reporting period.

An accumulated surplus arises when, for all fiscal periods from inception to date, the total operating surpluses exceed the total operating deficits. Operating surpluses (deficits) are the excess (deficiency) of revenue over expenses.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

AHS measures the accumulated surplus in order to identify any areas where the actual performance is changing relative to budget. This enables AHS to identify required changes in its operating plans to expand on positive outcomes or correct potential issues.

The Provincial Government has provided AHS with a five year Health Action Plan funding commitment from which AHS will provide future health care services to Albertans. Over this time period AHS must monitor its operating surpluses closely in order to ensure that the five year funding commitments are not exceeded and to ensure budget sustainability into the future. The annual funding limits from the Government are fixed per the plan and as such AHS must ensure that its planned expenses do not exceed these funding commitments. Knowing the AHS funding targets for the next five years allows AHS to make long term plans while maintaining budget control.

WHAT IS THE TARGET?

As at March 31, 2011, AHS had established $0 as the accumulated surplus budget. AHS is committed to having an accumulated surplus greater than $0 at the end of the five years.

Table: Accumulated Surplus (Deficit) as at:

	Actual ($ Millions)
March 31, 2010 - actual *	(527)
June 30, 2010 - actual	(385)
September 30, 2010 - actual	268
December 30, 2010 - actual	383
March 31, 2011 – actual *	116

Source: ** Audited Annual Financial Statements for the year ended March 31, 2011.*

▨ **PERFORMANCE STATUS**

Performance is better than annual target, continue to monitor.

2010/11 TARGET SURPLUS: $0

2010/11 ACTUAL ACCUMULATED SURPLUS: $116 M

HOW ARE WE DOING?

At March 31, 2011, the year end accumulated surplus was $116 million better than budget.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: From its inception, AHS has worked to establish consistent and comprehensive financial reporting across the organization. In view of staying on budget each year, AHS has developed Budget Monitoring Reports for the Executive Committee. AHS has also worked to improve our culture of accountability by creating a Program Governance Office to track progress of our major initiatives and identify investment opportunities.

Subsequent actions planned: We are currently implementing a process that will continuously monitor budgeted long term costs and revenues to ensure AHS meets the no accumulated deficit target at the end of the five year funding agreement. Implementation of an AHS integrated full service budget and planning module is also in progress.

WHAT ELSE DO WE KNOW?

The 2011 $116 million accumulated surplus is due to the one-time $527 million funding provided by the provincial government to cover the prior years' accumulated deficit. In addition, AHS generated $329 million of operating surplus, above the $527 million one-time funding, which was utilized for $67 million of internal restrictions for the South Health Campus and parking infrastructure reserve, $138 million for net internally funded capital purchases and $8 million for repayment of long term debt related to capital assets.

The approved AHS Operating Budget and Business Plan as well as the AHS Quarterly and Annual Audited Financial Statements can be obtained from the www.albertahealthservices.ca website.

HOW DO WE COMPARE?

National benchmark comparisons are not applicable.

Alberta Health Services

Performance Measure Update

Data updated quarterly.
Most current data is Q3 2010/11.
Next data update expected for Q1 2011/12.

Patient Satisfaction Adult Acute Care

■ **PERFORMANCE STATUS**

Performance is at or better than target, continue to monitor.

2010/11 TARGET: 80%

Q3 2010/11 ACTUAL: 82.2%

WHAT IS BEING MEASURED?

Patient satisfaction adult acute care measures the percentage of adults aged 18 years and older discharged from acute care facilities (hospitals) who rate their overall stay as eight, nine or ten on a zero to ten scale, where zero is the worst hospital possible and ten is the best.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

Gathering perceptions and feedback from individuals who use hospital acute care services is a critical aspect of measuring progress and improving the health system. This measure reflects overall patient perceptions associated with the hospital where they received care and is derived from a well-established Hospital Consumer Assessment of Healthcare Providers Survey (HCAHPS).

WHAT IS THE TARGET?

Alberta Health Services (AHS) has established a target of 80 per cent of patients rating their overall hospital stay as eight, nine or ten.

HOW ARE WE DOING?

The percentage of adults rating their overall hospital stay as eight, nine or ten is above the target of 80 per cent.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: HCAHPS continues to be rolled out province-wide, which will allow AHS to report by province, zone and site. As a result of the evolving strategic and quality needs of AHS, a decision was made in late 2010 to assess patient satisfaction at all sites on a yearly basis (based on proportional random sampling for each hospital). Over time data will be collected in a variety of ways to reflect patient experience and prompt actions for improvement.

Table: HCACHPS Satisfaction Survey Results

Year 2010/11	Q1	Q2	Q3
Number of Respondents	1581	1515	2244
Valid Answers	1573	1509	2234
Number of Sites	29	29	93
Rated experience as 8 to 10	84.5%	84.6%	82.2%

Source: *Alberta Health Services*

Subsequent actions planned: While the H-CAHPS survey tool currently provides valuable data regarding patient satisfaction in acute care, strategies will be developed to establish a comprehensive approach for measuring patient experience. This approach may include the review of data from multiple sources such as satisfaction surveys, the patient concerns process, and commendations. The early 2011 launch of a Feedback and Concerns Tracking (FACT) system will allow this data to be captured and analyzed with a view to establishing provincial best practices. In addition, local improvement initiatives shown to have a strong influence on patient satisfaction will be shared across the system.

WHAT ELSE DO WE KNOW?

The HCAHPS survey has not been validated for patients with psychiatric diagnoses. An indicator specific to Patient Satisfaction within Addictions and Mental Health is under development.

HOW DO WE COMPARE?

Comparable HCAHPS data from other provinces are not available. Using a similar measure Alberta ranked ninth among the 10 provinces for satisfaction with hospital services received in 2007. Alberta = 78.5 per cent, Best Performing Province = 87.8 percent (New Brunswick), Canada = 81.5 per cent (Statistics Canada, 2007). Using a similar measure Alberta ranked 10th among the 10 provinces for satisfaction with their last hospital stay for one or more nights. Alberta = 75 per cent, Best Performing Province = 90 per cent (Prince Edward Island), Canada = 79 per cent (Angus Reid 2009-2010).

Alberta Health Services

Performance Measure Update

Percentage of Patient Feedback as Commendations

New measure Q4 2010/11.
Data updated quarterly.
Next data update expected for Q1 2011/12.

WHAT IS BEING MEASURED?

This measure calculates the number of commendations received as a percentage of all feedback received by the Alberta Health Services (AHS) Patient Relations Department.

All patient feedback received by the Patient Relations Department is classed as Commendations, Concerns or Questions. The Patient Relations Department also tracks Consultations and Advisements regarding patient concerns received from internal staff. This allows for provincial reporting broken down by locations, programs, and categories/subject of feedback.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

It is important for AHS to learn what is working well for patients and families, as well as areas for improvement. Tracking the percentage of commendations received of all patient feedback assists AHS in assessing the quality of our services and determining if quality improvements are having an impact on patients and families. In addition, the results allow our staff to see where their dedicated efforts are making a difference in people's lives.

WHAT IS THE TARGET?

A consistent provincial method for tracking patient feedback received by the Patient Relations Department has only been possible since November of 2010 when a new provincial database was implemented. Time is still required to establish benchmarks and identify targets for growth.

Table: Patient Commendations

	Total	
	# Commendations	Per cent
Q4 2010/11	**252**	**9.12%**

PERFORMANCE STATUS

Performance Target for 2010 / 2011 has not been established for comparison.

2010/11 TARGET:
TBD

Q4 ACTUAL:
9.12 %

HOW ARE WE DOING?

Of the 2,764 pieces of feedback provided to the Patient Relations Department between January-March, 2011 (including Covenant Health), 9.12 per cent were commendations.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A provincial Database has been implemented with consistent processes for documenting and reporting on patient feedback. The patient feedback process has also been reviewed to ensure accessibility for patients/families who wish to provide direct feedback to AHS.

Subsequent actions planned: Ongoing tracking and reporting of patient feedback will continue and over the course of the next year benchmarks will be established and targets developed. New reporting tools will also be developed to enable more robust reporting that will separate data from Covenant Health. Processes will also be reviewed to simplify the process for patients and families to provide AHS with direct feedback.

WHAT ELSE DO WE KNOW?

Public messaging and staff education is also being developed on how to provide patient feedback directly to AHS.

Information is available by zone.

HOW DO WE COMPARE?

This measure is not benchmarked externally.

Alberta Health
Services

TIP
#2

Performance Measure Update

Percentage of Patient Concerns Escalated to Patient Concerns Officer

New measure Q4 2010/11.
Data updated quarterly.
Next data update expected for Q1 2011/12.

PERFORMANCE STATUS

Performance Target for 2010 / 2011 has not been established for comparison

2010/11 TARGET:
TBD

Q4 ACTUAL:
0.29 %

WHAT IS BEING MEASURED?

This measure calculates the per cent of concerns referred to a Patient Concerns Officer at the conclusion of a review with Patient Relations for the same complaint.

Individuals are encouraged to work with their care team to address any service delivery issues or they may work with the Patient Relations Department. However, some patients/families prefer not to work with either the healthcare team or the Patient Relations Department or may remain dissatisfied with the outcome of the concerns resolution process. These patients/families are referred to the AHS Patient Concerns Officer to conduct an independent investigation as required by provincial regulation.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

AHS addresses concerns with patients/families as part of our commitment to the provision of quality care and engagement with patients/families. Patient feedback is important to inform quality improvements and it is essential that patients/families feel there is an avenue to express their concerns.

If patients do not feel they can discuss their concerns at the service delivery level, or if they feel concerns are not adequately addressed when referred to the Patient Relations Department, then it is an indication that there is need for AHS to better engage with patients/families and that trust needs to be built with the public.

WHAT IS THE TARGET?

Provincial tracking of concerns in a consistent manner has only been possible since November of 2010 when a new provincial database was implemented. This is the first quarter for which it has been possible to provide accurate data on concerns that have been consistently tracked, so time is still required to establish benchmarks and identify targets for growth.

Table: Patient Concerns Officer Reviews Initiated

	Total	
	#	%
Q4 2010/11	**6**	**0.29%**

Source: Alberta Health Services

HOW ARE WE DOING?

During the period of January-March, 2011 six Patient Concerns Officer reviews were initiated on files that had been reviewed by the Patient Relations Department, which amounted to 0.29 per cent.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A provincial database has been implemented with consistent processes for documenting and reporting on patient feedback. The Patient Concerns Resolution Process has also been reviewed to ensure accessibility to the Patient Concerns Officer for patients/families who prefer to address their concerns through this avenue.

Subsequent actions planned: Ongoing tracking and reporting of concerns will continue and over the course of the next year benchmarks will be established and targets developed. Processes will also be reviewed to simplify access to the concerns resolution process to better enable AHS to engage with patients and families.

WHAT ELSE DO WE KNOW?

Public messaging and staff education is also being developed on how to access the patient concerns resolution process.

Information is available by zone.

HOW DO WE COMPARE?

This measure is not benchmarked externally.

Performance Measure Update

Albertans Reporting Unexpected Harm

Data updated every two years.
Most current data is 2010.
Next survey is anticipated for 2012

PERFORMANCE STATUS

Performance is at or better than target, continue to monitor.

2010/11 TARGET: 9%

2010 ACTUAL: 9.0%

WHAT IS BEING MEASURED?

The Health Quality Council of Alberta (HQCA) asks Albertans about unexpected harm in the Health Services Satisfaction Survey, which is conducted every two years. The most recent report was released in 2010 and is based on data collected between February and May 2010.

Unexpected harm measures the per cent of Albertans reporting unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

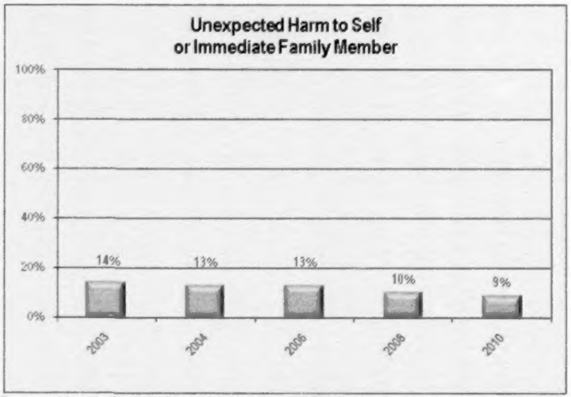
Patient experience with adverse events is a high level indicator of system safety. Unlike complications, which may occur as an expected risk of some treatments, unexpected harm can affect a patient's health and/or quality of life and can result in additional or prolonged treatment, pain or suffering, disability or death.

WHAT IS THE TARGET?

Based on previous survey data, AHS has established a 2010/11 target of 9 per cent for Albertans reporting unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year.

HOW ARE WE DOING?

The per cent of Albertans reporting unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year is at the target of 9 per cent.



Source: Health Quality Council of Alberta (HQCA) Health Services Satisfaction Survey

Note: This measure applies only to adults aged 18 years and over who used health care services in Alberta in the past year.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Safety alert and safer practices notices are disseminated to frontline care teams as required. As well, a province-wide reporting and learning system has been implemented and will be used to analyze patient safety related adverse events, close calls and hazards and also recommend solutions to decrease adverse events or unexpected harm. In addition, a draft patient safety plan has been developed which contains a number of initiatives to improve patient safety.

Subsequent actions planned: Risk reduction strategies will be established to prioritize actions on reported adverse events, close calls and hazards. As well, options will be investigated to allow for potential self-reporting of unexpected harm from patients and families. Policies/procedures for disclosing harm to patients, and also for the management of serious adverse events will be implemented. Measurement and action plans for controlling specific hospital-acquired infections (e.g. MRSA, C-difficile, central venous catheter bloodstream infections) will also be implemented in 2011 and 2012.

WHAT ELSE DO WE KNOW?

The origins of unexpected harm are complex and the contributing factors are not always clear. Further analysis is necessary in order to guide future decisions and to gain an understanding of what has occurred. Though it may be impossible to eliminate unexpected harm entirely, it is feasible to continually learn and improve systems and processes in order to minimize harm.

Information is available by zone.

HOW DO WE COMPARE?

National benchmark comparisons are not available.

Performance Measure Update

Patient Satisfaction
Emergency Department

Data updated every two years.
Most current data is 2010.
Next survey is anticipated for 2012

WHAT IS BEING MEASURED?

The Health Quality Council of Alberta (HQCA) asks Albertans about their satisfaction with Emergency Department in the Health Services Satisfaction Survey, which is conducted every two years. The most recent report was released in 2010 and is based on data collected between Feb to May 2010.

Patient Satisfaction Emergency Department (ED) measures the per cent of Albertans who were satisfied (4 or 5 out of 5) with their or a close family member's services at an Alberta Health Services emergency department in the past year.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

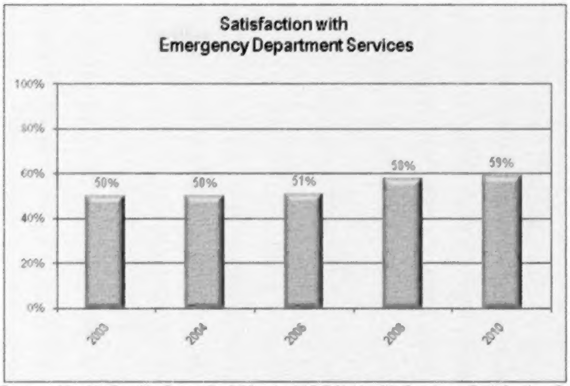
Patient satisfaction with the emergency department is a crucial and critical dimension of quality; it is a high level indicator of the structure, process and outcome of care in emergency departments. The information provides insights into the consequences of policy and strategic changes from the perspective of a key health care partner - Albertans.

WHAT IS THE TARGET?

AHS has not yet established a 2010/11 target for patient satisfaction with the emergency department.

HOW ARE WE DOING?

In 2010 59 per cent of Albertans were satisfied with their or a close family member's services at an emergency department in the past year.



Source: Health Quality Council of Alberta (HQCA) Health Services Satisfaction Survey

Note: This measure applies only to adults aged 18 years and over who had gone to an emergency department in the past year for an illness or injury for themselves or a close family member.

PERFORMANCE STATUS

Performance Target for 2010/11 has not been established for comparison.

2010/11 TARGET: TBD

2010 ACTUAL: 59%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A total of 323 new hospital beds have been opened in Calgary/Edmonton as of March 31, 2011 and additional staff (physicians/unit managers/ Home Care coordinators) have been added. "Over capacity" protocols and escalation plans continue to be used to manage periods of peak pressures in ED.

Subsequent actions planned: EDs are working collaboratively with other sectors to help patients avoid unnecessary (avoidable) ED visits and return home with appropriate services so as to minimize return visits. Additional hospital beds will be opened with a view to meeting the target of 360 new spaces by June/2011. New software will be implemented to make hospital discharges more efficient and timely.

WHAT ELSE DO WE KNOW?

Research conducted with Calgary emergency department users identified public expectations of emergency department care. These included: staff communication with patients; appropriate waiting times; the triage process; information management; quality of care; and improvement to existing services. These expectations were held similarly by those who had recently used the emergency department and those who had not. The authors also concluded that "emergency department care providers understand some, but not all, of the public's expectations. (Watt, Wertzler and Brannan. 2005. *Patient expectations of emergency care: phase I – a focus group study*. Canadian Journal of Emergency Medicine).

Information is available by zone.

HOW DO WE COMPARE?

Alberta ranked ninth among the 10 provinces for satisfaction with hospital emergency rooms. Alberta = 55 per cent, Best Performing Province = 67 per cent (British Columbia), Canada = 56 per cent (Angus Reid, 2009-2010).

Performance Measure Update

Patient Satisfaction
Health Care Services Personally Received

Data updated every two years.
Most current data is 2010.
Next survey is anticipated for 2012

WHAT IS BEING MEASURED?

The Health Quality Council of Alberta (HQCA) asks Albertans about satisfaction with health care services in the Health Services Satisfaction Survey, which is conducted every two years. The most recent report was released in 2010 and is based on data collected between February and May 2010.

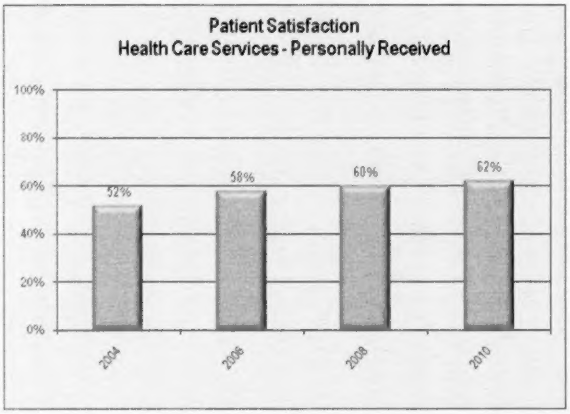
Patient Satisfaction Health Care Services Personally Received measures the per cent of Albertans who were satisfied (4 or 5 out of 5) with the health care services they personally received in Alberta within the past year.

Health care services include personal family doctor, other health care professionals at family doctor's office, community walk-in clinics, specialists, MRI, other diagnostic imaging, pharmacists, emergency departments, inpatient hospital services, outpatient hospital services and mental health services.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

Patient satisfaction with health care services received is a crucial and critical dimension of quality; it is an indicator of the structure, process and outcome of care in Alberta's health care system. The information provides high level insights into the consequences of policy and strategic changes from the perspective of a key health care partner - Albertans.



Source: Health Quality Council of Alberta (HQCA) Health Services Satisfaction Survey

Note: This measure applies only to adults aged 18 years and over who used health care services in Alberta in the past year.

△ **PERFORMANCE STATUS**

Performance is within acceptable range, monitor and take action as appropriate.

2010/11 TARGET: 65%

2010 ACTUAL: 62%

WHAT IS THE TARGET?

Alberta Health Services (AHS) has established a 2010/11 target of 65 per cent of Albertans who were satisfied with the health care services they personally received in Alberta within the past year.

HOW ARE WE DOING?

The per cent of Albertans who were satisfied with the health care services they personally received in Alberta within the past year was 62 per cent (below target).

WHAT ACTIONS ARE WE TAKING?

AHS is undertaking focused improvement activities in access areas including Emergency Department and Primary Care Physician as well as specialty services such as Cancer Treatment and Surgery.

WHAT ELSE DO WE KNOW?

From the public's perspective, access – the ease of obtaining health care services – continues to be the most important factor associated with their overall satisfaction with health care services received.

Information is available by zone.

HOW DO WE COMPARE?

Alberta ranked 10th among the 10 provinces for satisfaction with health care services received. Alberta = 81.0 per cent, Best Performing Province = 90.5 per cent (New Brunswick), Canada = 85.7 per cent (Statistics Canada, 2007)

Performance Measure Update

Patient Satisfaction
Mental Health Services in Alberta

Data updated every two years.
Most current data is 2010.
Next survey is anticipated for 2012

WHAT IS BEING MEASURED?

The Health Quality Council of Alberta (HQCA) asks Albertans about satisfaction with mental health services in the Health Services Satisfaction Survey, which is conducted every two years. The most recent report was released in 2010 and is based on data collected between February and May 2010.

Patient Satisfaction Mental Health Services measures the per cent of Albertans who were satisfied (4 or 5 out of 5) with the mental health services they received from a therapist, counselor, family doctor, psychologist, or psychiatrist.

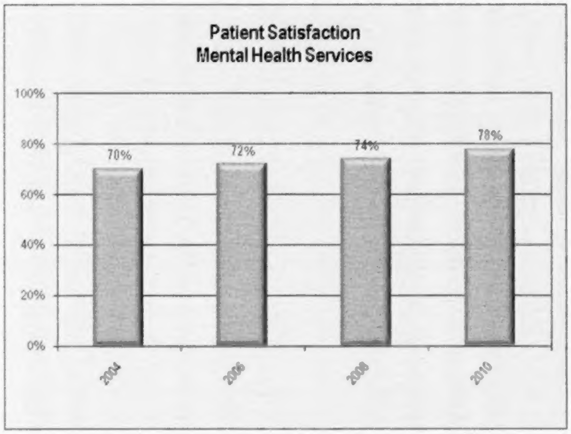
Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

Patient satisfaction with mental health services is a crucial and critical dimension of quality; it is a high level indicator of the structure, process and outcome of care. The information provides insights into the consequences of policy and strategic changes from the perspective of a key health care partner - Albertans.

WHAT IS THE TARGET?

Alberta Health Services (AHS) has not yet established a 2010/11 target for patient satisfaction with mental health services.


Patient Satisfaction
Mental Health Services

Source: Health Quality Council of Alberta (HQCA) Health Services Satisfaction Survey

Note: This measure applies only to adults aged 18 years and over who used mental health care services in Alberta in the past year.

PERFORMANCE STATUS

Performance Target for 2010/11 has not been established for comparison.

2010/11 TARGET: TBD

2010 ACTUAL: 78%

HOW ARE WE DOING?

In 2010 78 per cent of Albertans were satisfied with the mental health services they received.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Family and patient representatives are included as members on various committees and working groups, which allows for client focused direct input into program planning and design. The 106 Bed Geriatric Psychiatry Program from Alberta Hospital Edmonton (AHE) has been relocated to Villa Caritas, with plans to expand the program. The clinical pathway for adult depression in primary care is complete and has been piloted in one family physician office with four family physicians. Access to mental health services in corrections centres has been increased through the recruitment of additional staff and provision of training to corrections staff to enhance their understanding and awareness of addiction and mental health issues amongst the offender population. Partnerships have been established between AHS and stakeholder organizations that provide services to at-risk youth and young adults aged 12 to 24. Mentoring and training of staff in stakeholder organizations is also ongoing.

Subsequent actions planned: AHS will begin assessing patient satisfaction on a quarterly basis later in 2011. Results will be used at the local level to identify site-specific improvement opportunities for increasing satisfaction, as well as areas where services have excelled. In addition, the clinical pathway for adult depression will be deployed across all five zones in 2011 and 2012.

WHAT ELSE DO WE KNOW?

Information is available by zone.

HOW DO WE COMPARE?

National benchmark comparisons are not available.

Alberta Health
Services